Arkansas Department of Human Services

Division of Behavioral Health Sciences

Office of Alcohol and Drug Abuse Prevention

RADD

Regional Alcohol and Drug Detoxification

Regional Alcohol and Drug Detoxification Manual
Office of Alcohol and Drug Abuse Prevention
305 South Palm Street
Little Rock, Arkansas 72204
501-686-9866
501-686-9035 (fax)

STATE OF ARKANSAS

Regional Alcohol and Drug Abuse Prevention Manual

Revised July 1, 2009

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Forward

The primary goal of the Regional Alcohol and Drug Detoxification (RADD) program is to provide Quality detoxification treatment services, while managing limited allotted resources. Meeting the unique needs of Arkansans, by insuring proper and timely placement, is the desired outcome of this process. The RADD manual is intended to be a comprehensive guide for nurses, clinical staff, program administrators, and individuals involved in planning, evaluating, and providing alcohol and/or other detoxification services.

All providers of RADD Services will adhere to the *ADAP Rules of Practice and Procedure, revised 2009* and the *ADAP Licensure Standards for Alcohol and/or Other Drug Treatment Programs, revised 2009.*

Questions concerning the RADD program procedure should be directed to the Director of Treatment Services or the RADD Coordinator at 501-686-9866. Questions regarding Admission and Data Management Information System (ADMIS) reporting should be directed to the Records Analyst at 501-686-9872.

What is Detoxification?

What is intoxicate?

What is addictive?

Detoxification (i.e. Detox) is the management of the withdrawal syndrome and overall removal of toxic or addictive substances from the body through a set of medical interventions while reducing the physical harm typically present with drug or alcohol (AOD) abuse. Detoxification is an attempt to bring an AOD abuser's body back to a regulatory state after long-term use of any harmful substance.

The term *detoxification* encompasses a clearing of toxins. For many AOD-dependents, removal of drugs from their bodies is part of the detoxification process. In the context of treating patients who are physically dependent on alcohol or other drugs, detoxification also includes the period of time during which the body's physiology is adjusting to the absence of drugs. Detoxification is not a treatment for drug-seeking behavior, but is a family of procedures for alleviating the short-term symptoms of withdrawal from drug dependence. Detoxification is the first step in the recovery process. It must also include a period of psychological readjustment designed to prepare the patient to take the next step in ongoing treatment.

Alcohol and other drug (AOD) detoxification is the process through which a person who is physically dependent on alcohol, illegal drugs, prescription medications (or a combination of these drugs) withdraws from the drug or drug of dependence. Since most persons who have a substance use disorder are addicted to a combination of alcohol/or other drugs (polydrug abuse), detoxification often involves more than one substance.

Intoxicate is to excite or stupefy by alcohol or a drug to the point where physical and mental control is markedly diminished. When an individual abuses any substance to achieve intoxication, he/she experiences altered states of mind and body functions.

Addictive is a compulsive need for and use of a habit-forming substance characterized by tolerance and by well-defined physiological symptoms upon withdrawal. Clinical research studies, over many years, have compounded evidence that an individual suffering with an addictive disorder may attribute it to biological, pharmacological, and/or social reasons.

Addiction, within the medical sector, is typically diagnosed as a disease which causes a motivation to maintain a devotion to a substance which presents a damaging result either through physiological or psychological dependence.

Physical addiction or dependence results in very identifiable withdrawal characteristics when the substance(s) of said addict are removed from use. Physically addictive substances often induce pleasure and relieve pain with initial use, and abuse begins when the fear of losing pleasurable qualities and regaining painful experiences ensues.

Psychological addiction or dependence, although found beyond substances, produces a compulsive behavior and leads to a multitude of withdrawal symptoms. Psychological addiction relates directly to the brain.

While both physical and psychological addiction can occur simultaneously, the treatment of abuse can be drastically different. Research-based evidence leaning toward addiction as a disease is largely becoming accepted in the medical community, coupled with factors such as genetic predisposition and cultural pressures. Addiction and dependency propel individuals to fight a chronic cycle in which life becomes a mission for engaging in a set role of behaviors while ceasing or limiting other behaviors.

Length of Detoxification

Often, detoxification entails a more intense level of care than other types of AOD treatment. The detoxification period is defined as: **the period during which the patient receives detoxification medications, and/or period measured by the duration of withdrawal signs or symptoms.** It is essential that all employees and detox staff adhere to the policies surrounding detoxification in order to ensure client health and safety while managing the detoxification process.

Role of Detoxification in AOD Abuse Treatment

For many AOD-dependent patients, detoxification is the beginning phase of treatment. It can also be a time when patients begin to make the psychological readjustments necessary for ongoing treatment. Offering detoxification alone, without follow-up to an appropriate level of care, is an inadequate use of limited resources. People who have severe problems that predate their AOD dependence or addiction (such as: family disintegration, lack of job skills, illiteracy, or psychiatric disorders) may continue to have these problems after detoxification unless specific services are available to help them deal with these factors.

Goals of Detoxification

- To provide safe withdrawal from the drug(s) of dependence and enable the client to become drug free
- To provide withdrawal that is humane and protects the client's dignity while preparing the client for ongoing treatment of their dependence
- To provide quality DETOX and related treatment services to the most people while managing limited allotted resources

To provide a safe withdrawal from the drug (s) of dependence and enable the patient to become drug free.

Many risks are associated with withdrawal, some influenced by the setting. For persons who are severely dependent on alcohol, abrupt and unsupervised cessation of drinking may result in delirium tremens or death. Other sedative-hypnotics may produce life-threatening withdrawal syndromes. Withdrawal from opiates produce severe discomfort. However, risks to the patient and society are not limited to the severity of the patient's physical disturbance, particularly when detoxification is conducted in an outpatient setting. Outpatients experiencing withdrawal symptoms may self-medicate with street drugs. The resulting interaction between prescribed medication and street drugs may result in sedation, a drop in blood pressure, even overdose.

To provide withdrawal that is humane and protects the patients' dignity.

A supportive environment with caring staff that are sensitive to cultural issues, and confidentiality are all-important to providing humane withdrawal.

To prepare patient for ongoing treatment of his or her AOD dependence.

During detoxification, patients may form therapeutic relationships with treatment staff or other patients and become aware of alternatives to an AOD-abusing lifestyle. Detoxification is an opportunity to offer patients information and to motivate them for longer-term treatment.

Principles of Detoxification

- Detoxification alone is rarely adequate treatment for AOD dependencies.
- When using medication regimens or other detoxification procedures, clinicians should use only protocols of established safety and efficacy.
- Providers must advise patients when procedures are used that have not been established as safe and effective.
- During detoxification, providers should control patients' access to medication to the greatest extent possible.
- Initiation of withdrawal should be individualized.
- Whenever possible, clinicians should substitute a long-acting medication for short-acting drugs of addiction.
- The intensity of withdrawal cannot always be predicted accurately.
- Every means possible should be used to reduce the patients' signs and symptoms of AOD withdrawal.
- Patients should begin particpating as soon as possible in followup support therapy such as peer group therapy, family therapy, individual counseling or therapy, 12-step recovery meetings, and AOD recovery educational programs.

Principles of Detoxification

Some detoxification procedures are specific to particular drugs of dependence; others are based on general principles of treatment and are not drug specific.

Detoxification alone is rarely adequate treatment for alcohol and other drug (AOD) dependencies. The provision of detoxification services without follow-up to an appropriate level of care is less than optimum use of limited resources. The appropriate level of care following detoxification must be a clinical decision based on the individual needs of the patient.

When using medication regimens or other detoxification procedures, only protocols of established safety and efficacy should be used in routine clinical practice.

Providers must advise patients when procedures are used that have not been established as safe and effective. Such protocols are considered investigatory and should be carried out under an approved research protocol.

During detoxification, providers should control patients' access to medication to the greatest extent possible. Patients who are AOD dependent generally cannot be relied on to take their medication as prescribed. Overdose, with either the prescribed medication or other drugs, is always a possibility. Because of this, treatment staff should administer as many of the patient's detoxification medications as possible. When it is not possible for the treatment staff to do so, another responsible person should assist the patient in taking the prescribed detoxification medication.

Initiation of withdrawal should be individualized. Many persons come to treatment during times of personal crisis. To initiate withdrawal immediately may intensify their distress. In some cases, treatment staff may prefer to stabilize the patient on medication (e.g., a patient using heroin may be stabilized on methadone) to resolve the immediate crisis before initiating withdrawal.

The intensity of withdrawal cannot always be predicted accurately. To assign patients to the appropriate level of care, it would be desirable to have empirically validated predictors of withdrawal severity. Unfortunately, no validated objective measures exist that would enable providers to predict with confidence a particular patient's intensity of withdrawal symptoms. Clinical guidelines used to assess probable withdrawal severity include the amount and duration of patients' AOD use, the severity of their prior withdrawals (if any), and the presence of medical or psychiatric co-morbidity. Clinicians should take into account the patient's medical history but should also be aware that it cannot be considered totally reliable.

Every means possible should be used to lessen the patient's signs and symptoms of AOD withdrawal. Medication should not be the only component of treatment. Psychological support is extremely important in reducing patients' distress during detoxification. Also, to the extent that it is medically safe, patients should be physically active.

Patients should begin participating as soon as possible in follow-up support therapy such as peer therapy, family therapy, individual counseling or therapy, 12-step recovery meetings, and AOD recovery educational programs. Such services provide much needed emotional support and provide alternative methods of coping with stresses that trigger AOD abuse. They provide general methods of coping with stresses that trigger AOD abuse. They provide general information about AOD dependence and goals for recovery. Overall health also can be addressed. Counseling on sexual health may include information on sexually transmitted diseases, human immunodeficiency virus (HIV) testing and education, and guidance on safer sexual practices. For injecting drug users, a drug recovery education program might include a discussion of the Center for Disease Control and Prevention recommendations on needle exchange and disinfections.

Effects of AOD Exposure and Withdrawal

Tolerance and Physical Dependence

Continued exposure to AODs induces adaptive changes in an individual's brain cells and neural functioning. The changes vary depending on the drug of abuse. The term "neuroadaptation" is often used to refer to these changes. One result of neuroadaptation is drug tolerance, that is, increasing the amounts of the drug that are required to produce the same effect. A second consequence of neuroadaptation is physical dependence; the brain cells require the drug in order to function.

Drug Withdrawal

Sudden removal of alcohol or another drug of abuse from a physically dependent individual produces either an abstinence or withdrawal syndrome. The abstinence syndrome for each drug follows a predictable time course and has predictable signs and symptoms. ***Signs*** are defined by Webster's Medical Dictionary as, "...objective evidence of disease especially as observed and interpreted by the physician rather than by the patient or lay observer." ***Symptoms*** are defined in the same text as: "...subjective evidence of disease or physical disturbance observed by the patient."

The signs and symptoms of drug withdrawal are usually the reverse of the direct pharmacological effects of the drug. Heroin use commonly produces elevation of mood (euphoria), a decrease in anxiety, insensitivity to pain (analgesia), and a decrease in the activity of the large intestine, often causing constipation. On the other hand, heroin withdrawal produces an unpleasant mood (dysphoria), pain, anxiety, and over activity of the large intestine, often resulting in diarrhea. Alcohol usually reduces anxiety and causes sedation. Large quantities may produce sleep, coma, or even death by respiratory depression. In a person who is physically dependent, cessation of alcohol use produces anxiety, insomnia, hallucinations, and seizures.

Tolerance and Withdrawal are the Hallmarks of Physiological Dependence

Determine the presence of tolerance or withdrawal, as documented in DSM-IV diagnostic criteria:

~ A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.

~ Markedly diminished effect with continued use of the same amount of alcohol.

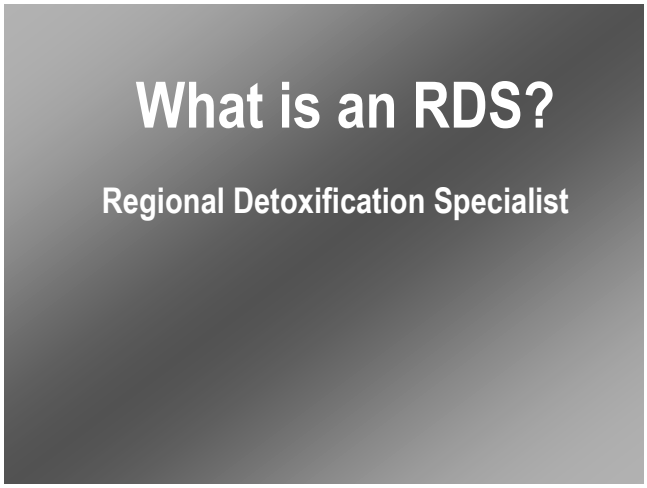
Withdrawal: (one of the following)

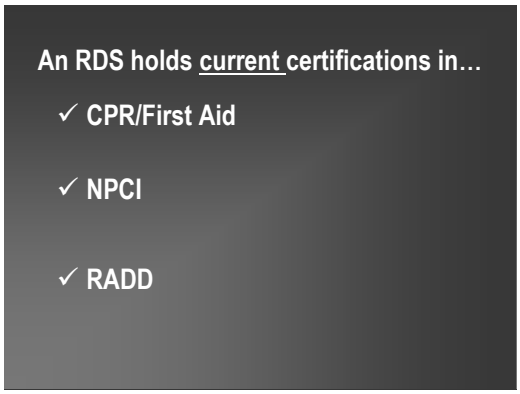
~ The characteristic withdrawal syndrome for the substance (refer to DSM-IV for further details).

~ The same for (or closely-related) substance is taken to relieve or avoid withdrawal symptoms.

Safe and effective withdrawal management can occur in a variety of environments that differ in the level of care and professional monitoring that they provide. This module contains a review of the five levels of detoxification care outlined by the American Society of Addiction Medicine (ASAM). The objective of placing patients into the appropriate level of care is to ensure safety during detoxification in the least restrictive environment and promote long-term, successful recovery.

For short-acting drugs such as alcohol and heroin, the most severe signs and symptoms of withdrawal usually begin within hours of the individual's last use. With a long-acting drug or medication, such as diazepam (Valium), withdrawal symptoms may not begin for several days and usually reach peak intensity after 5 to 10 days. The most severe drug-withdrawal symptoms, during the initial stages of detoxification, constitute the acute abstinence syndrome. The adjective "acute" distinguishes the syndrome from a "chronic" or protracted abstinence syndrome, in which signs and symptoms of withdrawal may continue for weeks to months after cessation of use.





A Regional Detoxification Specialist must have valid and up-to-date certifications in First Aid and CPR, Nonviolent Physical Crisis Intervention, and Regional Alcohol and Drug Detoxification training. If staff are not licensed medical professionals, or are without the previous trainings and certifications, they cannot monitor clients during the detoxification process.

RDS Responsibilities

- Screening applicants
- Evaluating presenting symptoms
- Compiling an accurate substance abuse history
- Taking vital signs
- Nonviolently diffusing hostile situations
- Providing CPR/First Aid
- Documenting any occurrence relative to the detox process

Emergency Care Plan

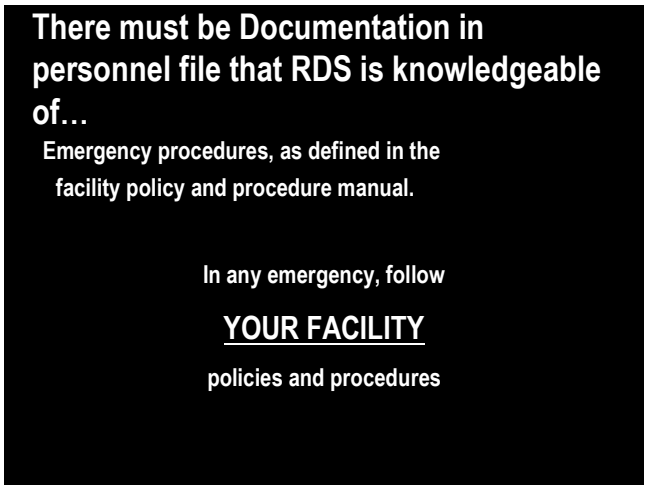
The program will maintain a written emergency care plan that will include the following:

1. At least 3 staff members trained as Regional Detoxification Specialists.

2. The program does provide 24-hour availability of emergency services including adequate provision for handling special and difficult circumstance, when it is determined that an emergency exists.

3. The program maintains written agreements with ambulance services, doctors, hospitals, etc., to provide medical coverage for emergency situations at all times.

4. The program maintains a list of the available services including phone numbers.

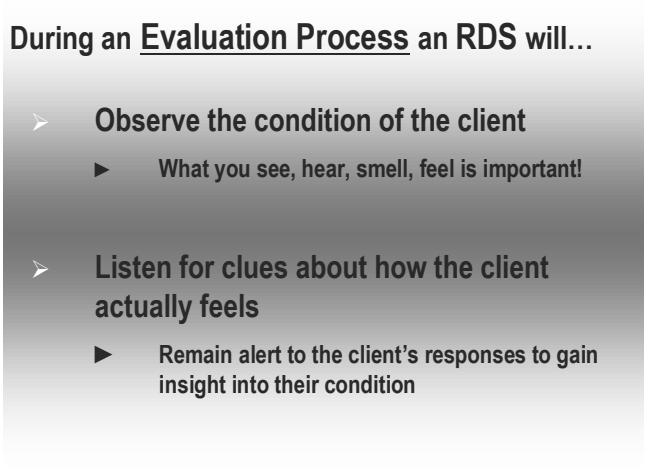


The Evaluation Process

The Regional Detoxification Specialist (RDS) will be in control of the evaluation process at all times. The goal of the evaluation is:

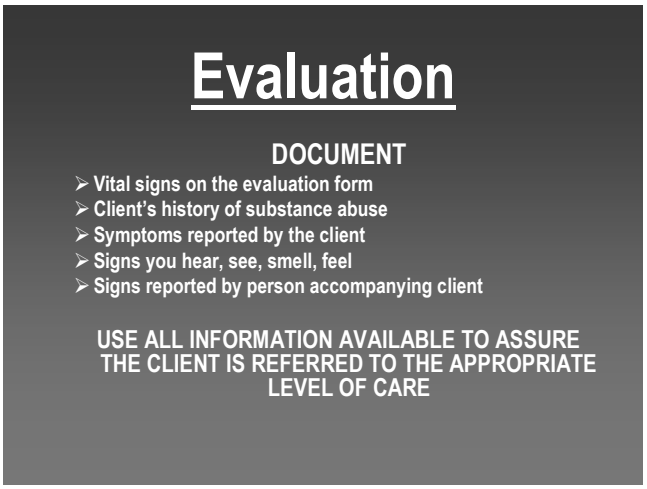
(1) to reassure the person that you are concerned about his/her welfare and condition

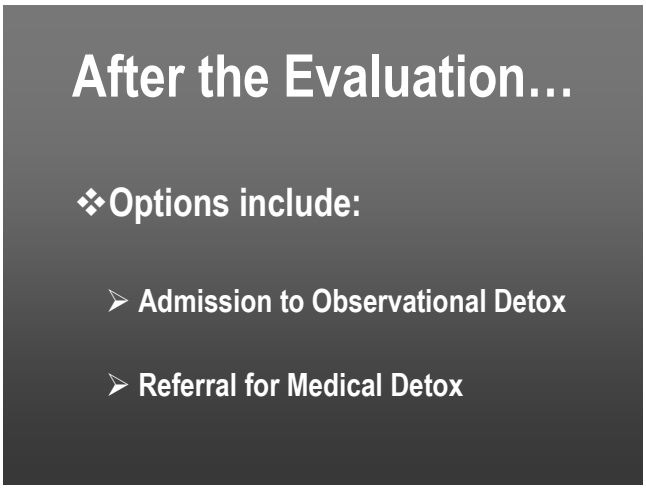
(2) to gain as much insight as possible into the persons; physical and mental condition to make the proper referral



Evaluation

The RDS will always observe the condition of the client and listen for clues on how he/she actually feels. The Withdrawal Risk Assessment form will be completed with vital signs, as well as, history of substance abuse (see Form section). The RDS will always be alert to the responses to gain more insight into the client's condition. Always ask any accompanying person what signs and symptoms the person has been exhibiting (hearing voices, tremulous, etc.). Using all the information that is available can assure the client is referred to the appropriate level of service.





Defusing Hostile Situations

The RDS should always be alert to the client's response to various things happening in the admission environment, such as their responses to questions, being examined, etc. If a situation starts presenting a hostile tone, the RDS should reassure the individual that they are there to help, and he/she needs the full cooperation of the individual to ensure services can be provided as soon as possible. There should not be an atmosphere of confrontation. The RDS should never put him/herself in a situation of being hurt. If the situation deteriorates to the point where the evaluation process is stopped or the individual becomes non-cooperative, contacting the police should always be an option for a combative situation.

Documentation

As the evaluation/examination process unfolds, appropriate documentation should take place.

IF IT IS NOT DOCUMENTED, IT DID NOT HAPPEN!

Document the evaluation on the Withdrawal Risk Form so it can enhance the referral/treatment process. Always fully document admissions, dispositions of the admissions, and refusals.

Follow up with a descriptive narrative of the client's disposition, basing the decision on:

- Vital signs
- Presenting signs and symptoms
- Substance abuse history

Always consider the welfare of the client when reaching a referral decision. At this point, if a person wants to be admitted and the RDS finds it appropriate, the RDS will have the client sign a Voluntary Admission Agreement. The RDS will refer the client to one of two levels of service based upon the evaluation:

- Medical detoxification
- Observational detoxification

Records

Upon admission to the Regional Alcohol and Drug Detoxification (RADD) Program, a chart will compiled. The chart will include the following:

1. Withdrawal Risk Assessment
2. Commitment Papers (VOL or CCO-Act 10/1268)
3. Release of Confidential Information Forms
4. Condition of Admission Form
5. Client's Personal Property Form
6. Vital Signs
7. Regional Detoxification Specialist's notes (Progress Notes)
8. Stabilization/Treatment Plan
9. Aftercare Plan
10. Proof of Client's Identity

Referral Sources

Upon completion of the evaluation process, based upon vital signs, presenting signs and symptoms, and substance abuse history, the client will be referred to one of the following levels of service:

A. Clients in an acute phase of withdrawal will be referred to the appropriate medical facility for medical detoxification. Upon discharge from the medical facility, the client will be returned to the alcohol and other drug (AOD) treatment facility and placed in RADD services followed by continued care.

B. Clients who are in mild withdrawal will be placed in the observational level f the RADD program. Following discharge from observation, the client will be placed in RADD services followed by continued care.

Treatment

Observation includes periodic monitoring on a 24-hour/day basis of a client who is undergoing mild to moderate withdrawal in a residential/live-in setting. Monitoring will consist of taking the client's vital signs every two hours or more frequently if indicated, until results remain within the normal range for at least eight hours. A staff member that is trained and certified by the Office of Alcohol and Drug Abuse Prevention will take vital signs. The facility shall establish approved emergency medical procedures. These services shall be available should the client's condition deteriorate and advanced medical care is required. Vital signs will be recorded on the "Vital Sign" sheet with any emergency comments. Once vital signs are within normal limits for 8 consecutive hours, they will be taken no less than every 6 hours. There will be documentation in the client's case record verifying each vital sign taken during the client's stay in detoxification.

Stabilization

Staff, authorized by the program, will identify the client's short-term needs (based on withdrawal risk assessment and medical history) and develop an appropriate detoxification/stabilization plan (see Form section). The plan will be signed by an RDS, LPN, LPTN, RN, or MD and the client, unless the client is unable to do so due to medical contraindications. If the client is unable to sign the plan, the staff will explain the circumstances in the client's record and obtain the signature as soon as possible. The completed and signed detoxification plan will be filed in the client's record within 8 hours of admission. The program will implement the detoxification/stabilization plan, and document the client's response to interventions in the progress notes. The program will also review, and if necessary, revise the detoxification/stabilization at minimum of every 24-hour period. Should the client's need change significantly within 24-hours, the plan will need to be revised earlier.

Aftercare

Prior to discharge, a continued plan of care will be developed. The aftercare plan is initiated to help in facilitating the ongoing process of treatment for an individual. The RDS and the client will sign the plan. The client's needs, established goals, and objectives or ways in which those needs will be met, are included in the aftercare plan. The plan will designate a staff person and date with which the client will follow through for review of aftercare status.

Medication

Upon admission, clients who bring prescribed medication to the facility should be allowed to continue it. Allowable medications include, but are not limited to:

- heart medications
- high blood pressure medications
- psychotropic drugs (used in treating psychiatric disorders)
- diabetic medications
- ulcer medications
- breathing medications (tablets and inhalers)
- seizure medications

Medications that should be scrutinized closely include sleeping pills, tranquillizers, diet pills, etc. The treatment facility should not discontinue prescribed medications without input from a physician. Clients returning from detoxification in a medical unit should continue to take any medication prescribed at that facility. Also, medication taken at the facility should be documented in the RDS's notes. If any prescribed medication is discontinued, this should be reflected in the RDS notes (why, when, and physician's input).

Legal and Ethical Issues for Detoxification Programs
A host of legal and ethical issues affect the operation of alcohol and other drug (AOD) detoxification programs, in particular obtaining consent to treat. For example, staff members often deal with patients who are inebriated or intoxicated. How can they obtain consent to enter detoxification treatment from such individuals?

Consent to Treatment
Adults generally have the right to consent to or to refuse treatment , a right that is grounded in State law, judicial decision, and the United States Constitution. The right to consent to treatment, in other words, to make an informed choice, is normally based upon a process. The treatment provider presents the patient with a diagnosis, a prognosis, a description of available alternative treatments, their risks and benefits, and a prediction of the likely outcome if there is no treatment. This process requires that the patient have the ability, sometimes called "decisional capacity," to make an informed choice.

Intoxicated or Incapacitated Patients
Detoxification programs, perhaps more than any other kind of AOD abuse treatment program, deal with patients whose capacity to make rational decisions may be impaired. Persons who are intoxicated often demonstrate diminished mental capacity. Individuals who are incapacitated by AODs may be unconscious, or their judgment may be so impaired that they are incapable of making a rational decision about their basic needs, including their need for treatment.

How can detoxification programs secure consent when the patient's decisional capacity is diminished?

Staff should assess each patient in order to determine whether he or she is able to give informed consent. If a patient is not able to do so because he or she is intoxicated or incapacitated by AOD use, the program should obtain consent as soon as the patient has regained his or her faculties. In the meantime, the program may obtain consent to treat from a relative or parents, if the patient is accompanied to the program. In obtaining consent, the program must be aware of the Federal confidentiality laws.

Standards of Care
RADD programs handle patients who are brought in by the police, by relatives, or are "involuntarily committed" to treatment by the courts. (Involuntary commitment is also known as "protective custody" and "emergency commitment.")

Admission Priority

Court ordered clients
- Arkansas Commitment Law
- Act 10 (Act 1268 of 1995 as amended)

Client with greatest clinical need
- IV drug users and pregnant women first

Clients from your catchment area

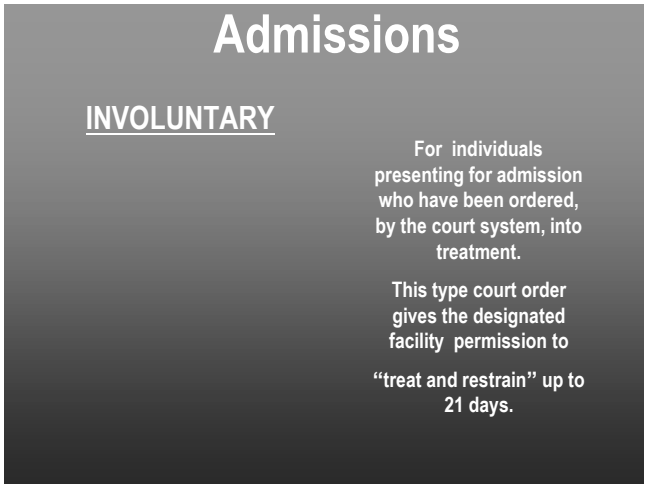
Clients from other catchment areas in the state of Arkansas

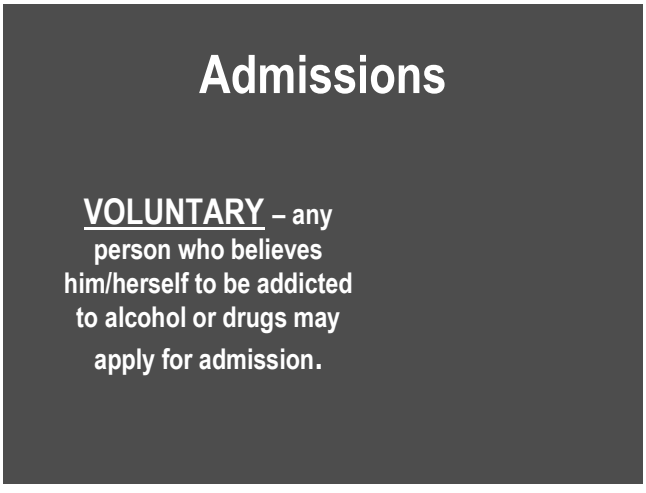
Admission

For each new admission, re-admission, or transfer admission, the client must be interviewed. The interview **MUST** be documented. During the intake process, it is important to document that an effort has been made to ensure the client understands policies and procedures, services available, costs, client rights and program rules. Also upon admission, the risk assessment will be initiated, completed, and filed in the client record within 24 hours of admission. If the client's physical condition constitutes a medical emergency preventing completion of documentation, an explanation of the circumstances should be placed in the client record and the information should be obtained as soon as possible.

Types of Admission

Individuals presenting themselves for RADD program services will be evaluated by a Regional Detoxification Specialist. Admission to the RADD program includes: **ACT 10 (ACT 1268 OF 1995 Amended)** - the voluntary and involuntary commitment law for substance abuse.





Involuntary clients are entitled to the same care that meets professional standards

Denial of Admission

Overriding medical problems: A client who presents any of the following medical conditions will be referred to the appropriate medical facility for treatment prior to be admitted into any RADD program.

- Broken bones
- Bleeding wound (s), including nose bleeds
- Excessive bruising, especially on the face or head
- Seizure disorder
- Diabetes
- High blood pressure
- Chest pin
- Excessive vomiting (blood or blood tinged)
- Protruding abdomen (distended)
- Jaundice

- Note: You may not deny admission due to intoxication! *

The RDS will write a refusal noted explaining the **REASON(S)** refused, **ALTERNATIVE(S)** suggested, and **REFERRAL(S)** made. Care will be taken by the RDS to ensure the applicant is referred to the appropriate service.

Program staff must be aware of federal and state regulations and laws governing the dispensing, storage , and inventory of all medications. These laws and regulations often require that certain classes of professionals dispense medications. Separate provisions often govern the storage, prescription, and dispensing of scheduled drugs.

Drugs Brought into the Program by Patients

Patients sometimes enter AOD detoxification with drugs on their person or in their luggage. Staff may wish to search all newly admitted patients and the belongings they bring with them. The safest approach is to tell the patient at admission that this is a standard part of the process and that he or she must agree to the search in order to enter detoxification. The program also may incorporate this notice in its admission papers, thereby ensuring that the patient agrees to it in writing.

State regulations sometimes govern how a program may dispose of drugs. They may require, for example, that the drugs be flushed down the toilet, destroyed, or turned over to the police. (The Federal confidentiality laws and regulations, however, prohibit programs from turning patients who are in possession of drugs over to the police.) If a program does destroy drugs brought into treatment by patients, it is advisable for staff members responsible for such destruction to carry it out under observation and maintain a record of the act, so that a patient cannot later make false accusations about what occurred. State regulations also govern the methods for handling prescription and over-the-counter medications that patients bring into treatment.

Drugs Brought into the Program by Visitors

Although programs cannot turn patients with illegal drugs over to the police, no such restrictions apply to visitors who enter the program facility with drugs. As long as no disclosure is made about a patient, such persons may be reported to the police. A program that plans to search visitors for drugs must obtain their consent. It may make visiting privileges contingent on consent to search. The use of force should be avoided, as a visitor could sue the program for battery or false imprisonment.

Federal Law Protecting Patient's Right to Confidentiality

Federal laws (42 U.S.C. "290dd-2 (1992) and federal regulations (C.F.R. Part 2), and the Legal Action Center's Confidentiality and Communication 2003 guarantee the strict confidentiality of information about all persons receiving AOD abuse prevention and treatment services. They are designed to protect privacy rights and thereby attract individuals into treatment. Violating the regulations is punishable by a fine of up to $500 for the first offense or up to $5,000 for each subsequent offense.

The Federal confidentiality laws and regulations protect any information about a patient if the patient has applied for or received any alcohol or drug abuse related services including: assessment, diagnosis, detoxification, counseling, group counseling, treatment, and referral for treatment from a covered program. The restrictions on disclosure apply to any information that would identify the patient as an AOD abuser, either directly or by implication. The rule applies from the moment the patient makes an appointment. It applies to patients who are civilly or involuntarily committed, minor patients, patients who are mandated into treatment by the criminal justice system, and former patients. Finally, the rule applies whether or not the person making the inquiry already has the information, has other ways of getting it, enjoys official status, is authorized by State law, or comes armed with a subpoena or search warrant.

Conditions Under Which Confidential Information May Be Shared

Information that is protected by federal confidentiality regulations may always be disclosed after the patient has signed a proper consent form. The regulations also permit disclosure without the patient's consent in several situations, including communicating information to medical personnel during a medical emergency or reporting child abuse to the authorities.

The following required items merit further explanation:

⇒ The purpose of the disclosure
⇒ How much and what kind of information will be disclosed.

These two items are closely related. All disclosures, especially those made pursuant to a consent form, must be limited to information that is necessary to accomplish the need for or purpose of the disclosure. It would be improper to disclose everything in a patient's file if the person making the request needed only one specific piece of information.

In completing a consent form, one must determine the purpose of or need for the communication of information. Once this has been identified, it is easier to determine how much and what kind of information will be disclosed and to restrict the disclosure to what is essential to accomplish the identified need or purpose. As an illustration, if a patient needs to have the fact that he or she has entered a detoxification program verified in order to be eligible for a benefit program, the purpose of the disclosure would be "to verify treatment status," and the amount and kind of information to be disclosed would be "enrollment in treatment." The disclosure would then be limited to a statement that "Jane Doe [the patient] is receiving a counseling at XYZ Program."

⇒ The patient's right to revoke consent

The patient may revoke consent at any time, and the consent form must include a statement to this effect. Revocation need not be in writing. If a program has made a disclosure prior to the revocation, the program has "acted in reliance" on the consent and is not required to try to retrieve the information it has already disclosed.

The regulations state that acting in reliance includes providing services in reliance on a consent form permitting disclosures to a third-payer payer. Thus, a program may bill the third-party payer for past services to the patient even after consent has been revoked. A program may not, however, make any disclosure to the third-party payer in order to receive reimbursement for services provided after the patient has revoked consent.

⇒ Expiration of the consent form

The form must also contain a date, an event, or a condition on which it will expire, if not previously revoked. Consent must last "no longer than reasonably necessary to serve the purpose for which it is given." If the purpose of the disclosure is expected to be accomplished in 5 or 10 days, it is better to stipulate that amount of time rather than to request a longer period or have a uniform 60 or 90 day expiration date for all forms.

The consent form may specify an event or a condition for expiration, rather than a date. For example, if a patient has been placed on probation at work on the condition that he or she attend the detoxification program, the consent form should not expire until the expected time of completion of the probationary period.

⇒ Signatures of minors and parental consent

Seeking Information from Collateral and Referral Sources

Making inquiries of parents, other relatives, health care providers, employers, schools, or criminal justice agencies might seem at first glance to pose no risk to a patient's right to confidentiality, particularly if the person or entity approached for information referred the patient to treatment. Nonetheless, it does. When a program that screens, assesses, or treats a patient asks a relative or parent, a doctor, an employer, or a school to verify information it has obtained from the patient, it is making a "patient-identifying disclosure." Patient-identifying information is information that identifies someone as an AOD abuser. In other words, when program staff seeks information from other sources, they are letting these sources know that the patient has asked for detoxification services. Federal regulations generally prohibit this kind of disclosure, unless the patient consents.

How should a program go about making such requests? The easiest way is to get the patient's consent to contact the relative, doctor, employer, school, or health care facility. When filling out the consent form, staff should give thought to the "purpose of disclosure" and "how much and what kind of information is to be disclosed." For example, if a program is assessing a patient for treatment and seeks records from a mental health provider, the purpose of the disclosure would be "to obtain mental health treatment records to complete the assessment." The "kind of information disclosed" would be limited to a statement that "John Doe is being assessed by the XYZ Program." No other information about John Doe would be released.

Communications with Insurance Carriers

Programs must obtain a patient's written consent on the form required by federal regulations in order to communicate with any third-party payer who may be responsible for funding the patient's treatment. What should programs do in these circumstances?

The program clearly cannot make a disclosure to a third-party payer without the patient's consent. If the third-party payer is the patient's employer, the program would not only be violating federal regulations. Some patients do not want their treatment reported to the insurer. Patients whose employers are self-insured may fear they will be fired, demoted, or disciplined, should their employer learn they have a substance abuse problem. Patients whose treatment is covered by health insurance may fear they will lose their benefits and be unable to obtain other coverage once their current insurer discovers they have been treated for a substance abuse problem.

Communication with Other Care Providers

Detoxification programs sometimes need to maintain ongoing communication with the referral source or with other professionals providing services to patients. The best way to proceed is to get the patient's consent.

Referral for Further Treatment

When a staff member of a detoxification program refers a patient to another treatment program and makes an appointment for the patient, he or she is making a disclosure covered by federal regulations—a disclosure that the patient has sought or received detoxification services. A consent form is, therefore, required. If the detoxification program is part of a larger program to which the patient is being referred, a consent form may not be necessary under federal rules, since there is an expectation for information disclosed to staff within the same program.

Transferring Patients to the Hospital

Detoxification programs, particularly those with limited medical resources, often must transfer patients to a hospital for intensive medical management and care. Programs may deal with this issue in two ways. First, they may ask all patients admitted to detoxification to sign a consent form permitting disclosure to the cooperating hospital, should hospitalization be required. Second, they may take advantage of a provision in the Federal regulations that permits a program to make disclosures in a "medical emergency" to medical personnel "who have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual." The regulations define "medical emergency" as "a condition which poses an immediate threat to the patient's condition and which requires immediate medical intervention." If a patient's condition requires emergency treatment, the program may use this exception to communicate with medical personnel at a hospital. Whenever a disclosure is made to cope with a medical emergency, the program must document in the patient's records the name and affiliation of the recipient of the information, the name of the individual making the disclosure, the date and time of the disclosure, and the nature of the emergency.

Mandatory Reporting to Public Health Authorities

All states require that new cases of acquired immunodeficiency syndrome be reported to public health authorities, which submit this information to the Federal Centers for Disease Control and Prevention. In some cases, they also use it for other purposes. Some states also require the reporting of new cases of human immunodeficiency virus infection. States also require reporting of certain infectious diseases, such as tuberculosis and sexually transmitted diseases. The public health authority often uses reports of infectious diseases to engage in "contact tracing," that is, finding others whom an infected person may have spread the disease.

The types of information that must be reported and for which diseases, who must report, and the purposes to which the information is put, vary from state to state. Therefore, program directors must examine their state laws to discover (1) whether they or any member of their staff is a mandated reporter, (2) when reporting is required, (3) what information must be reported and whether it includes patient-identifying information, and (4) what will be done with the information reported.

Telephone Calls to Patients

If someone telephones a patient at a detoxification program, the staff may not reveal that the patient is at the program unless the program has a written consent form signed by a patient to make a disclosure to that particular caller. Given this restriction, how should a program handle telephone calls to patients? There are at least four options:

- ⇒ The program can obtain the patient's written consent to accept telephone calls from particular people and consult a list these individuals' names when the patient receives a phone call.
- ⇒ If the patient has not consented to receive calls from a particular person, the staff member can put the caller on hold and ask the patient if he or she wants to speak to the caller. If the patient wants to accept the call, the patient, not the staff member, is making the disclosure that he or she is at the detoxification program. If the patient does not want to speak to the caller, the staff member must tell the caller, "I'm sorry, but I can't tell you whether John Doe is here." At no time may the program reveal, even indirectly, that the person being inquired after is a patient at the program.
- ⇒ The program can uniformly take messages for patients, telling all callers, "I'm sorry, but I cannot tell you if Jane Doe is here, but if she is I will give her this message." Again, this leave it up to the patient whether to make a disclosure about being in treatment.
- ⇒ The program can set up a "patient phone" that is answered only by patients. Since only patients would answer the telephone and give the phone numbers to others if the number were unlisted, the program would be making no disclosures. The program should caution patients to act discreetly and thoughtfully when handling calls for others.

Patients Mandated into Treatment by the Criminal Justice System

Detoxification programs treating patients who are required to enter and participate in treatment as part of a criminal justice sanction must follow the Federal confidentiality rules. In addition, some special rules apply when a patient is in treatment as an official condition of probation, sentence, dismissal of charges, release from detention, or other disposition of any criminal proceeding, and information is being disclosed to the mandating agency.

A consent form or court order is still required before any disclosure may be made about an offender who is mandated into assessment or treatment. However, the rules concerning the length of time that consent remains valid are different, and "criminal justice system consent" may not be revoked before its expiration event or date.

The regulations require that the following factors be considered in determining how long a criminal justice system consent will remain in effect:

⇒ The anticipated duration of treatment
⇒ The type of criminal proceeding in which the offender is involved
⇒ The need for treatment information in dealing with the proceeding
⇒ When the final disposition will occur
⇒ Anything else the patient, program or criminal justice agency believes is relevant

These rules allow programs to continue to use a traditional expiration condition for a consent form that once was the only one allowed, namely, "when there is a substantial change in the patient's criminal justice system status." A substantial change in status occurs whenever the patient moves from one phase of the criminal justice system to the next. For example, if a patient is on probation or parole, a change in criminal justice status would occur when the probation or parole ended, either successful completion or revocation. Thus, the program could provide treatment or periodic reports to the probation or parole officer monitoring the patient and could even testify at a revocation hearing if it so desired, since no change in criminal justice status would occur until after that hearing. This formula appears to work well.

Concerning revocability of the consent (i.e., the conditions under which the offender can take back his or her consent), the regulations provide that the form may state that consent may not be revoked until a specified date arrives or condition occurs. The regulations permit the criminal justice system consent form to be irrevocable, so that a patient who has agreed to enter treatment in lieu of prosecution or punishment cannot later prevent the court, probation department, or other agency from monitoring his or her progress. Although criminal justice system consent may be made irrevocable for a specified period of time, its irrevocability must end no later than the final disposition of the criminal proceeding. Thereafter, the patient may freely revoke consent.

Several other considerations relating to criminal justice system referrals are important. First, any information received by one of the eligible criminal justice agencies from a treatment program may be used by that justice agency only in connection with its official duties with respect to that particular criminal proceeding. The information may not be used in other proceedings, for other purposes, or with respect to other individuals. Second, whenever possible, the judge or referring agency should require that a proper criminal justice system consent form be signed by the patient at the time he or she is referred to the treatment program. If this is not possible, the treatment program should have the patient sign a criminal justice system consent form at his or her first appointment. With a properly signed criminal justice consent form, the detoxification program can communicate with the referring criminal justice agency, even if the patient appears for assessment or treatment only once. This avoids the problems that may arise if a patient mandated into treatment does not sign a proper consent form and leaves before the assessment or treatment has been completed.

If a program fails to have the patient sign a criminal justice system form and the patient fails to complete the assessment or treatment, the program has few options when faced with a request for information from the referring criminal justice agency. The program could attempt to locate the patient and ask him or her to sign a consent form. The patient is, however, unlikely to do so. It is uncertain whether a court can issue an order to authorize the program to release information about a referred patient who has left the program in this type of case, because the regulations allow a court to order disclosure of treatment information for the purpose of investigating or prosecuting a patient for a crime only when the crime was "extremely serious." A parole or probation violation generally will not meet the criterion.

Therefore, unless the judge, criminal justice agency, or program obtains consent at the beginning of the assessment or treatment process, the program may be prevented from providing any information to the referring criminal justice agency. If a patient referred by a criminal justice agency never applies for or receives services from a program, that fact may be communicated to the referring agency without patient consent. As soon as a patient has made an appointment to visit the program, a signed consent form or a court order is needed for any disclosures.

Duty to Warn

Patient Threats: For most treatment professionals, the decision whether to report a patient's threat to commit a crime is a troubling one. Many professionals believe that they have an obligation ethically, professionally, and morally to prevent a crime when they are in a position to do so, particularly if the crime is a serious one. Although these issues may not arise often, programs may face questions about their "duty to warn" someone of a patient's threatened suicide, a patient's threat to harm another, or a patient's insistence on driving while impaired.

There is a developing trend in the law to require therapists who have learned that a patient presents a "serious danger of violence to another" to take "reasonable steps" to protect an intended victim. This trend started with the case of *Tarasoff v. Regents of the Univ. of Cal.,* 17 Cal.3d 425 (1976), in which the California Supreme Court held a psychologist liable for monetary damages because he failed to warn a potential victim his patient threatened to, and then did, kill. The court ruled that if a psychologist knows that a patient poses a serious risk of violence to a particular person, the psychologist has a duty "to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstance."

While strictly speaking the *Tarasoff* ruling applies only in California, courts in a number of states have followed it in finding therapists and others liable for damages when they failed to warn a potential victim of threats disclosed during therapy by their patients. Most of these cases are limited to situations where patients threaten a specific victim;, and they do not generally apply where a patient makes a threat without identifying the intended target. States that have enacted laws on the subject have similarly limited the duty to warn to situations in which the identity of the potential victim has been revealed.

Faced with a potential "duty to warn" question, program staff must answer two, or sometimes three, questions:

⇒ Is there a legal duty to warn in the particular situation under state law?
⇒ If there is no state legal requirement to warn an intended victim or the police, does the program believe a moral obligation to warn exists?

Only an attorney familiar with the law in the state in which the program operates may answer the first question. If the answer is "no," it is advisable to discuss the second question with a knowledgeable lawyer as well.

⇒ If the answer to either of the above questions is "yes," can the program warn the potential victim or someone likely to be able to take action without violating the federal confidentiality regulations?

There is an apparent conflict between federal confidentiality requirements and the duty to warn imposed by states that have adopted the principles of the *Tarasoff* case. Simply put, federal confidentiality law and regulations prohibit a program from making the type of disclosure that *Tarasoff* and similar cases require, unless it can do so by using one of the regulation's narrow exceptions.

When a patient threatens harm to self or another, a program has four options:

⇒ Request a court order before a judge authorizing the disclosure. The program must take care that the court abides by the requirements of federal confidentiality regulations.
⇒ Make a disclosure that does not identify, as a patient, the individual who threatens to commit the crime. The disclosure can be made either anonymously through a report, or (for a program that is part of an entity whose sole focus is not AOD treatment) making the report in the larger entity's name. For example, a counselor employed by a detoxification program that is part of a mental health facility could telephone the police of an attack, identify herself as a "counselor at the Johnson City Mental Health Clinic," and explain the risk. This would convey the vital information without identifying the patient as an AOD abuser. Counselors at freestanding detoxification units may not give the name of the program.
⇒ Make a report to "medical personnel" if the threat presents a "medical emergency" that poses an immediate threat to the health of any individual and "requires immediate medical intervention." For example, a program could notify a private physician about a suicidal patient so that medical intervention can be arranged.
⇒ Obtain the patient's consent. This may be unlikely, unless the patient is suicidal.

If none of these options are practical, and a program believes there is clear and imminent danger to a patient or another person, it is prudent to report the danger to the authorities or the threatened individual. While each case presents different questions, it is doubtful that any prosecution (or successful civil lawsuit) under the confidentiality regulations would be brought against a program or counselor who warned about potential violence when he or she believed in good faith that there was real danger to a particular individual. On the other hand, a civil lawsuit for failure to warn might well result if a threat were actually carried out. In any event, the program should try to make the warning in a manner that does not identify the individual as an AOD abuser.

Driving While Impaired

Suppose that an intoxicated patient arrives at a detoxification program but decides not to enter treatment. If the patient is not in condition to drive home, a program should:

⇒ Offer the patient a ride home or taxi fare for a ride home
⇒ Maintain a room where such a person can "sleep it off" (The program should obtain consent to alert his or her family.)

If an intoxicated individual refuses any of the above and insists on driving, the program should call the police if attempts to prevent the individual from driving fail. In doing so, it must take care not to violate the individual's confidentiality. For example, the program can call the police and tell them that "the driver of a 1991 tan Nissan with a license number XYZ 123, who is heading downtown from the intersection of Maple and 3rd Street, is not in a condition to operate a vehicle." The program should ask the police to respond immediately. The program may not tell the police that the patient is impaired by alcohol or drugs, and cannot reveal the program's name since doing so would suggest that individual has a substance abuse problem.

In order to get the patient's license number and a description of his or her car. It may be necessary to detain the patient. If it does so, the program should avoid using force, since the patient could sue the program for battery or false imprisonment.

Dealing with Police

Programs sometimes unknowingly admit patients who are sought by police. If the police discover that someone they are seeking is at the program and come armed with an arrest warrant, what should the program do? How should programs handle search warrants? The answer to these questions are quite different.

Arrest Warrants

An arrest warrant gives police the authority to search the program facilities; however, the program is not authorized to help the police by pointing out the offender. The unfortunate result is that the confidentiality of all patients in the program may be compromised when the police enter and search for a fugitive. There is no solution to this problem, unless the police secure a court order ,under which, would authorize the program to disclose the identity of the patient. If the program cannot convince the police to obtain a court order, it can try to convince the patient to surrender voluntarily. (Voluntary surrender by a patient is a disclosure by the patient, not the program.) It is usually in the patient's best interest to surrender voluntarily, since arrest is inevitable and cooperation may positively influence the prosecutor and judge when the question of bail arises. The risk is that the patient will attempt to escape, which might expose the program to a change of assisting unlawful escape. To reduce this possibility, the program, should work with the police so that law enforcement personnel have secured the area around the program.

Search Warrants

A search warrant does not authorize the program to permit the police to enter the premises. Even if signed by a judge, a search warrant is not the kind of "court order" that federal regulations require before the program can allow anyone to enter and see patients or patient records when patients have not consented. Law enforcement officials are unlikely to know about the restrictions of the federal regulations, however, and they will probably believe that a search warrant permits them to enter and search the program. What should a program do?

Presented with a search warrant, program staff should show the officer a copy of specific federal regulations and explain their restrictions. Staff can suggest that the officer obtain a court order that will authorize the program to make the disclosure called for in the search warrant. No harm will ordinarily be caused by resultant delay (although the police may not agree with this view). The program should call its lawyer and let him or her talk with the police. Failing that, a program could try to call the prosecutor who has sent the police, explain the regulations, and point out that any evidence seized without the proper court order may be excluded at trial since it will have been illegally seized.

If none of these steps work, the program must permit the police to enter. Refusal to obey direct order of the police may be a crime, even if the police are wrong, and forcible resistance would be unwise. If the program has made a good faith effort to convince the law enforcement authorities to pursue the proper route, it is unlikely that it would be held liable for allowing entry when argument fails.

Conclusion

Programs should develop protocols for dealing with arrest and search warrants and have a copy of federal regulations available at all times to show law enforcement officials. Programs should establish a relationship with an attorney who can be called upon to help in these situations. Finally, programs should reach out to law enforcement agencies before a crisis arises and work with them to develop ways of dealing with these issues. If the regulations are explained when there is no emergency and there can be no suspicion that the program is hiding anyone or anything, and a protocol is established, unpleasant confrontations may be avoided.

Reporting Criminal Activity by Patients

⇒ What should a program do when, for example, a patient tells a counselor that she intends to get her children some new clothes by shoplifting, a crime the counselor knows she has committed many times in the past?
⇒ Does a program have a responsibility to call the police when a patient discloses to a counselor that he or she participated in a serious crime some time in the past?
⇒ What can a program do when a patient commits a crime at the program or against an employee of the program?

Each of these questions require separate analysis.

Threatened Criminal Activity

A program generally does not have a duty to warn another person or the police about a patient's intended actions, unless the patient presents a serious danger of violence to an identifiable individual. In the example of a client claiming to plan to shoplift, without intent to harm or without identifying the store, can be dealt with therapeutically. Shoplifting is a petty crime and not something a program should necessarily report to the police.

Past Criminal Activity

Suppose that a patient admits during a counseling session that he killed someone during a robbery three months ago. Does the program have a responsibility to report murder?

In a situation where a program thinks it might have to report a past crime, three questions must be answered:

⇒ Is there a legal duty under state law to report the past criminal activity to the police?

The answer is generally no. In most states, there is no duty to report to the police a crime committed in the past. Even those states that continue to make failure to report a crime rarely prosecute violators of the law.

⇒ Does state law permit a counselor to report the crime to law enforcement authorities if he or she wants to?

Whether or not there is a legal obligation to report past crimes to the police, state law may protect conversations between counselors of detoxification program and their patients and may exempt counselors of detoxification programs and their patients from any requirement to report past criminal activity by patients. Such laws vary widely on the protection they accord communications between patients and counselors. In some states, admission of past crimes may be considered privileged, and counselors may be prohibited from reporting them. In others, admission may not be privileged. Moreover, each state uniquely defines the kinds of relationships protected. Whether a communication about past criminal activity is privileged (and therefore cannot be reported) may depend on the counselor's profession and whether he or she is state-licensed or certified. Any program that is concerned about this issue should ask a local attorney for an opinion letter about whether there is duty to report and whether any counselor-patient privilege exempts counselors from that duty.

⇒ If state law requires a report, or if it permits one and the program decided to make a report, how can the program comply with federal confidentiality regulations and state law?

Any program that decides to make a report to law enforcement authorities about a patient's prior criminal activity must do so without violating either federal confidentiality regulations or state laws. It may comply with federal regulations by following one of the first 3 methods described in the discussion of duty to warn, namely:

- It can make a report in a way that does not identify the individual as a patient in a detoxification program
- If the crime is sufficiently serious, it can obtain a court order permitting it to make a report
- If the patient is an offender who has been mandated into treatment by a criminal justice agency, the program can make a report to that agency provided it has a criminal justice system consent form signed by the patient that is worded broadly enough to allow disclosure of this sort of information

Because of the complicated nature of this issue, any program considering reporting a patient's admission of criminal activity should seek the advice of a lawyer familiar with local law as well as federal regulations.

Crimes on Program Premises or Against Program Personnel

When a patient has committed or threatens to commit a crime on program premises or against program personnel, the regulations are more straightforward. They permit the program to report the crime to a law enforcement agency or to seek its assistance. Without any special authorization, the program can disclose the circumstances of the incident, including the suspect's name, address, last known whereabouts, and status as a patient at the program.

Reporting Child Abuse and Neglect

All 50 states have statutes requiring reporting when there is reasonable cause to believe or suspect child abuse or neglect. While many state statutes are similar, each has different rules about what kinds of conditions must be reported, who must report and when, and how reports must be made.

Most states now require not only physicians, but educators and social workers to report child abuse. Most states require an immediate oral report, and many have toll-free numbers to facilitate reporting. Half of the states require both oral and written reports. All states extend immunity from prosecution to persons reporting child abuse and neglect. Most states provide for penalties for failure to report.

Because of the variations in state laws, programs should consult these documents to ensure that their reporting practices are in compliance. Since many state statutes require that staff report instances of abuse to administrators, who are then required to make an official report, programs concerned about this issue should establish reporting protocols under which staff may bring incidents of suspected child abuse to the attention of program administers, who must then shoulder the responsibility of make the mandated reports.

Federal confidentiality regulations permit programs to comply with state laws that require the reporting of child abuse and neglect. This exception to the general rule prohibiting disclosure of any information about a patient, however, applies only to initial reports of child abuse or neglect. Unless the patient consents or the appropriate court issues a special court order, programs may not respond to follow-up requests for information or subpoenas, even if the records are sought for use in civil or criminal proceedings resulting from the program's initial report.

Conducting Research

Research about and evaluation of the efficacy of different methods of detoxification are essential if advances in treatment are to be made. But can detoxification programs share patient-identifying information with researchers and program evaluators? The confidentiality regulations do permit programs to disclose patient-identifying information to researchers, auditors, and evaluators without patient consent, providing certain safeguards are met.

Research

Detoxification programs may disclose patient-identifying information to persons conducting "scientific research" if the program director determines that the researcher:

⇒ Is qualified to conduct research
⇒ Has a protocol under which patient-identifying information will be kept in accordance with the regulations' security provisions
⇒ Has provided a written statement from a group of three or more independent individuals who have reviewed the protocol and determined that it protects patients' rights.

Researchers are prohibited from identifying an individual patient in any report or from otherwise disclosing any patient identities, except back to the program.

Audit and Evaluation

Federal, state, and local government agencies that fund or are authorized to regulate a program, private entities that fund or provide third-party payments to a program, and peer review entities performing a utilization or quality control review, may review patient records on the program premises in order to conduct an audit or evaluation. Any person or entity that reviews patient records to perform an audit or conduct an evaluation, must agree in writing that it will use the information only to carry out the audit or evaluation and that it will re-disclose patient information only:

⇒ Back to the program
⇒ In accordance with a court order to investigate or prosecute the program
⇒ To a government agency overseeing Medicaid or Medicare audit or evaluation.

Any other person or entity that is determined by the program director to be qualified to conduct an audit or evaluation, and that agrees in writing to abide by the restrictions on re-disclosure, also may review patient records.

Follow-up Research

Research that follows patients for any period of time after they leave treatment presents a special challenge under federal regulations. The detoxification program, researchers, or evaluator who seeks to contact former patients to gain information about how they are fairing after leaving treatment, must do so without disclosing to others any information about their connection to the detoxification program. If follow-up contact is attempted by telephone, the caller must make sure he or she is talking to the patient before identifying himself or herself in connection to the detoxification program. For example, asking for "Jane Doe" when her husband or child has answered the phone, and announcing that one is calling from the "ABC Detoxification Program," or "Drug Research Corporation" violates the regulations. The program or research agency may form another entity without a hint of detoxification in its name (e.g., Health Research, Inc.). Whenever a representative of such an entity calls former patients, however, care must be taken that the patient is actually on the line before revealing any connection with the detoxification program.

If follow-up is done by mail, the return address should not disclose any information that could lead someone seeing the envelope to conclude that the addressee had been in treatment.

Five Other Exceptions to the General Confidentiality Rule

Communications that Do Not Disclose Patient-Identifying Information

Federal regulations permit programs to disclose information about a patient if the program reveals no patient-identifying information. Thus, a program may disclose information about a patient if that information does not identify the patient as an AOD abuser or does not verify anyone else's' identification of the patient as an AOD abuser.

A program may make a disclosure that does not identify a patient in two ways:

- ⇒ It may report aggregate data that give an overview of the patients served in the program or some portion of its population. For example, a program could tell the newspaper that in the last six months it had 43 patients, 10 female and 33 male.
- ⇒ A program may communicate information about a patient in a way that does not reveal the patient's status as an AOD abuse patient. For example, a program that provides services to patients with other problems or illnesses as well as AOD addiction may disclose information about a particular patient as long as the fact that the patient has a substance abuse problem is not revealed.

Programs that provide only alcohol or drug services, or that provide a full range of services but are not identified by the general public as drug or alcohol programs, cannot disclose information that identifies a patient under this exception. For example, a counselor calling from the "XYZ Detoxification Program" will automatically identify the patient as someone who got services from the program. However, a freestanding program may make "anonymous" disclosures, that is disclosures that do not mention the name of the program or other wise reveal the patient's status as an AOD abuser.

Court-Ordered Disclosures

A state or federal court may issue an authorizing order that will permit a program to make disclosure about a patient that would otherwise be forbidden. A court may issue one of these orders, however, only after it follows certain special procedures and makes particular determinations required by the regulations. A subpoena, search warrant, or arrest warrant signed by a judge is not sufficient (standing alone) to require or permit a program to disclose information.
Before a court can issue an authorizing order, the program and any patient whose records are sought must be given notice of the application for the order and some opportunity to make an oral or written statement to the court. Generally, the application and court order must use fictitious names for any known patient. All court proceedings in connection with the application must remain confidential, unless the patient requests otherwise.

Before issuing an authorizing order, the court must find that here is "good cause" for the disclosure. A court may find "good cause" only if it determines that the public interest and the need for disclosure outweigh any adverse effect that the disclosure will have on the patient, the doctor-patient or counselor-patient relationship. The order cannot not be issued until after the court has tried and documented unsuccessful ways of obtaining the information. A judge will examine the records before making a decision.

The court may order disclosure of "confidential communications" by a patient to the program only if the disclosure is necessary to protect against a threat to life or serious bodily injury or to investigate or prosecute an extremely serious crime (including child abuse), or is in connection with a proceeding at which the patient has already presented evidence concerning confidential communications.

Medical Emergencies

A program may make disclosures to public or private medical personnel "who have a need for information about a patient for the purpose of treating a condition which poses an immediate threat to the health of any individual." The regulations define "medical emergency" as a situation that poses an immediate threat to health and requires immediate medical intervention.

The medical emergency exception permits disclosure only to medical personnel. It cannot be used as the basis for a disclosure to the police or other nonmedical personnel, including parents. Under this exception, however, a program could notify a private physician about a suicidal patient so that medical intervention could be arranged. The physician, in turn, could notify a patient's parents or other relatives, as long as no mention to cope with a medical emergency, the program must document in the patient's records the name and affiliation of the recipient of the information, the name of the individual making the disclosure, the date and time of the disclosure, and the nature of the emergency.

Qualified Service Organization Agreements

If a program routinely needs to share certain information with an outside agency that provides services to the program, it can enter into a QSOA. A QSOA is a written agreement between a program and a person providing services to the program, in which that person:

⇒ Acknowledges that in receiving, storing, processing, or otherwise dealing with any patient records from the program, he or she is fully bound by (the federal confidentiality) regulations
⇒ Promises that, if necessary, he or she will resist in judicial proceedings any efforts to obtain access to patient records

A QSOA should be used only when an agency or official outside of the program, for example, a clinical laboratory or data-processing agency, is providing a service to the program itself. An example is when laboratory analysis or data processing is performed for the program outside the agency. A QSOA is not a substitute for individual consent in other situations. Disclosures under a QSOA must be limited to information that is needed by others so that the program can function effectively. QSOAs may not be used between programs providing alcohol and drug services.

Internal Program Communications

The federal regulations permit some information to be disclosed to individuals within the same program. The restrictions on disclosure between or among personnel having a need for the information in connection with their duties that arise out of the provision of diagnosis, treatment, or referral for treatment of AOD abuse if the communications are:
⇒ Within a program or
⇒ Between a program and an entity that has direct administrative control over that program.

In other words, staff (including full or part-time employees and unpaid volunteers) who have access to patient records because they work for or administratively direct the program may consult among themselves or otherwise share information if their substance abuse work so requires.

Does this exception allow a detoxification program that is part of a larger entity, such as a hospital, to share confidential information with others that are not part of the detoxification unit?

The answer is complicated. There are circumstances under which the detoxification unit may share information with other units that are part of the greater entity to which it belongs. Before such an internal communication system is set up within a large institution, however, it is essential that an expert in the area be consulted.

Other Requirements

Patient Notice and Access to Records

The federal confidentiality regulations require programs to notify patients of their right to confidentiality and to give them a written summary of the regulations' requirements. The notice and summary should be handed to patients when they enter the program or shortly thereafter. The regulations contain a sample notice that may be used for this purpose.

Unless state law grants the right of patient access to records, programs have the right to decide when to permit patients to view or obtain copies of their records. The federal regulations do not require programs to obtain written consent from patients before permitting them to see their own records.

Security of Records

Federal regulations require programs to keep written records in a secure room, locked file cabinet, safe, or other similar container. The program should establish written procedures that regulate access to and use of patient records. The program director or a single staff person should be designated to process inquiries and requests for information.

Conclusion

Administrators and staff members of AOD detoxification programs should become thoroughly familiar with the many legal issues affecting their work. Such knowledge can prevent costly mistakes. Because legal requirements often vary by state and change of time, it is also essential that programs find a reliable source to whom they may turn for up-to-date information, advice, and training.

6. *The DEA regulations permit "any person in possession of any controlled substance and desiring or required to dispose of such substance {to} request the special agent in charge of the administration in the area in which the person is located for authority and instructions to dispose of such substance," 21 C.F.R. 1307.21 (a). The regulation sets forth how such a request should be made. Subsection 1307.21 (d) specifically states that the regulation "shall not be construed as affecting or altering in any way the disposal of controlled substances through procedures provided in laws and regulations adopted by any state."*
7. *Only patients who have "applied for or received" services from a program are protected. If a patient has not personally sought help from the program or has not yet been evaluated or counseled by a program, the program is free to discuss the patient's drug or alcohol problems with others. The federal regulations govern from the moment the patient applies or the program first conducts an evaluation or begins counseling.*

Universal Precautions

Universal Precautions (UP) are measures which can be taken to prevent the transmission and spread of infectious diseases. UP apply to blood, bodily fluids, semen and vaginal secretions. UP protect you and the client from potential infection through the use of gloves, masks, aprons, and protective eyewear.

- Assume that **EVERY** client is infected! *

⇒ Wear latex gloves when there is a chance of being in contact with blood, semen, vaginal secretions, mucous membranes, or other body fluids (for example, during catheter care, when disposing of sanitary napkins, handling dirty laundry, cleaning a bathroom, or assisting with menstrual care, bowel care, and toileting). Wearing gloves is especially important when you have a wound or rash or opening in the skin on your hands.
⇒ Wash your hands carefully with soap and water before putting on the gloves and immediately after taking the gloves off. Immediately wash carefully any time you get blood or other bodily fluids on yourself.
⇒ Wash your hands before and after you go to the bathroom, prepare food, perform personal care and housecleaning tasks, and after physical contact with others. Use a nailbrush to scrub your hands. Paper towels are safest for drying, do not use damp towels to dry your hands.
⇒ Protect yourself and others by not preparing or handling food when you are ill or have open sores.
⇒ Use mild bleach solution (ten parts water to one part bleach) to clean up blood or other body fluids. Clean up spills immediately. Also use the bleach solution to soak or disinfect possibly contaminated surfaces, linens, clothing, or other objects. Be careful using bleach since it can remove color.
⇒ Avoid handling sharp objects (such as razors or needles) that might have come in contact with blood or body fluids. Carefully place them in a puncture-resistant container for disposal.
⇒ Wash most soiled laundry in a washer set on hot, and dry them in a dryer set on high. If they will be damaged at the highest heat, wash them according to manufacturer's instructions.
⇒ Do not eat, drink, apply cosmetics, or handle contact lenses in areas where exposure to blood or body fluids is possible.
⇒ Wash dishes and utensils in hot, soapy water. Rinse in very hot water and let them dry.
⇒ Notify those around you if you are ill or have a condition that might be contagious.

Understanding the
Why, When, What, Where and How
of…

Vital Signs

What are vital signs?

Vital signs are measurements of the body's most basic functions. They include:

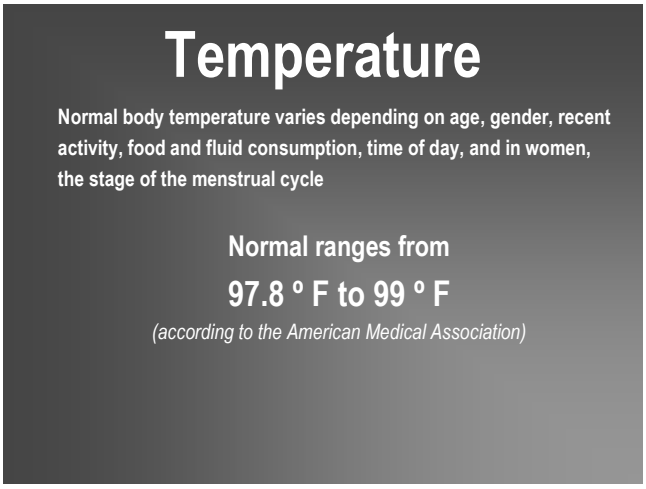
- Body temperature
- Pulse rate
- Respiration rate (rate of breathing)
- Blood pressure (Systolic/Diastolic)

Vital signs are useful in detecting or monitoring problems. Vital signs can be measured in a medical setting, at home, at the site of a medical emergency, or elsewhere.

When do you take vital signs?

Vital signs must be taken before a client is admitted. Proper documentation must be made of this, and every occurrence of vital sign measurement, to ensure all precautions are being made to obtain proper medical services if client's condition requires advanced medical care.
Once a client is admitted, vital must be taken at least every **TWO** (2) hours thereafter until client's measurements are within normal limits for eight (8) consecutive hours. However, a client's condition can change and present a need for more frequent taking of vital signs. If the client reports any nonspecific symptoms of physical distress, such as, feeling 'funny' or 'different,' additional checking of vital signs is required. If the client's physical condition changes, or before and after ingestion of certain medications, vital signs must be taken and documented. At any time, if client's vital signs become abnormal, VS must be taken every TWO (2) hours until within normal range for another eight (8) consecutive hours.

There must be documentation in the client's record verifying each vital sign taken during his/her stay in the detoxification unit.

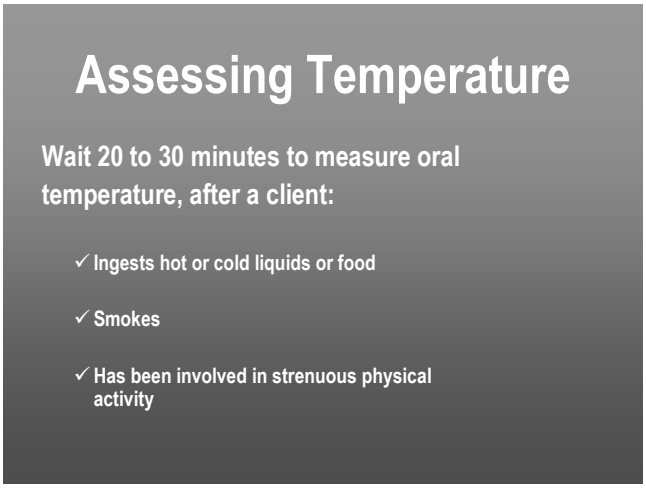


What is body temperature?

The normal temperature of a person varies depending on gender, recent activity, food and fluid consumption, and the time of day. In women, the stage of the menstrual cycle can affect temperature also. Normal body temperature, according to the American Medical Association, can range from 97.8°F to 99°F. A person's body temperature can by taken in a number of ways.

⇒ **Orally.** Temperature can be taken by mouth using either a glass mercury-filled thermometer, or a digital thermometer, which uses an electric probe to measure body temperature.
⇒ **Rectally.** Temperatures taken rectally (using a mercury or digital thermometer) tend to be 0.5—0.7° higher than those taken by mouth.
⇒ **Auxiliary.** Temperatures can be taken under the arm using a mercury or digital thermometer. Temperatures taken by this route tend to be 0.3—0.4° lower than those taken by mouth.
⇒ **By ear.** A special thermometer can quickly measure the temperature of the eardrum, which reflects the body's core temperature, or temperature of the internal organs.

Body temperature may be abnormal due to fever or hypothermia. A fever is indicated when body temperature rises above 98.6°F (orally) or 99.8°F (rectally). Hypothermia is defined as a drop in body temperature below 95°F.



Factors Affecting Body Temperature

A client's body temperature may show indication of fever or lowered body temperature not due to illness if any of the following are considered:

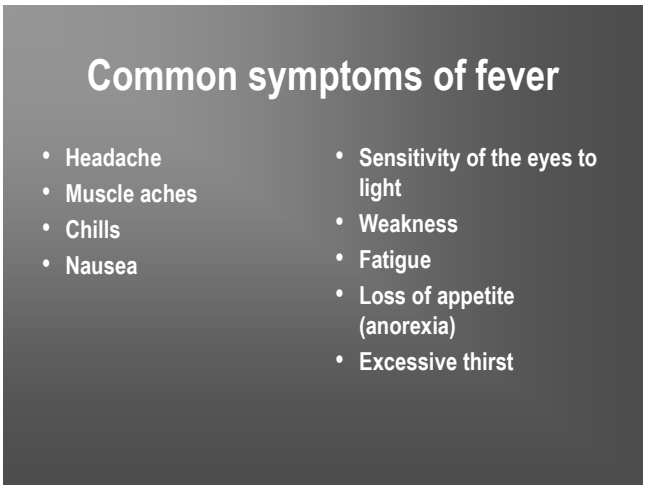
- Temperature is usually lowest between 1 and 4 PM
- Temperature rises during the day and peaks between 4 and 7 PM
- Patterns are not automatically reversed in night workers; it takes 1 to 3 weeks
- Optimal time to screen for fever is 6 PM

Assessing Temperature

Before a client's temperature is taken and recorded, a period of 20 to 30 minutes should be allotted after any of the following:
- A client ingests hot or cold liquids or food
- A client smokes
- A client has been involved in strenuous physical activity

Fever

If a client's temperature measures above 100.2°F, orally, and indication of infection is possible. As body temperature rises, metabolism increases, oxygen demand increases, thus causing respiratory rates to increase. Typically, if a client 's temperature stays below 102°F, low grade fevers are not harmful.



Possible observations of client suffering from fever:

- Sweating (Diaphoresis)
  Dry skin and mucous membranes indicate possible dehydration
- Confusion
- Restlessness
- Disorientation

Interventions for Fever

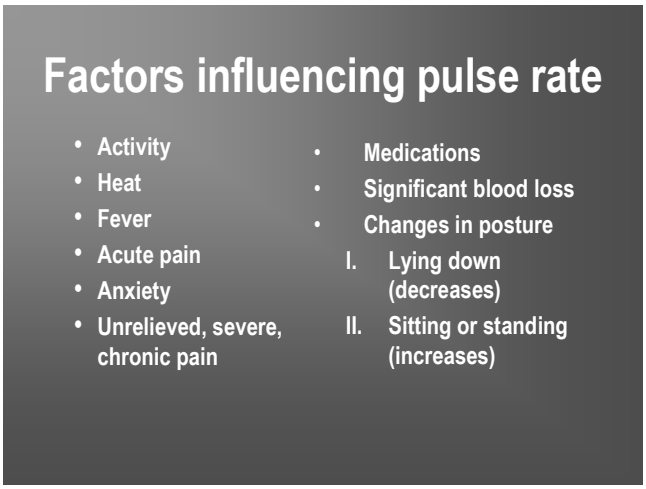
- Reduce external covering to promote heat loss
- Reduce activities; allow for rest
- Keep clothing and bed linen dry
- Discourage smoking
- Control temperature of environment
- Offer well-balanced meals
- Provide extra fluids
- Take temperature often, especially if client has experienced chills

What is pulse rate?

The pulse rate is a measurement of the heart rate, or the number or times the heart beats per minute. As the heart pushes blood through the arteries, the arteries expand and contract with the flow of the blood. Taking a pulse not only measures the heart rate, but also can indicate the following:

⇒ Heart rhythm
⇒ Strength of pulse (a weak pulse may indicate a fast heart beat in which some beats are too weak to feel, heart failure, or a low volume of blood in the circulatory system)

The normal pulse for healthy adults ranges from 60—100 beats per minute. The pulse rate may fluctuate with exercise, illness, injury, and emotions. Women, in general, tend to have faster heart rates than do boys and men.



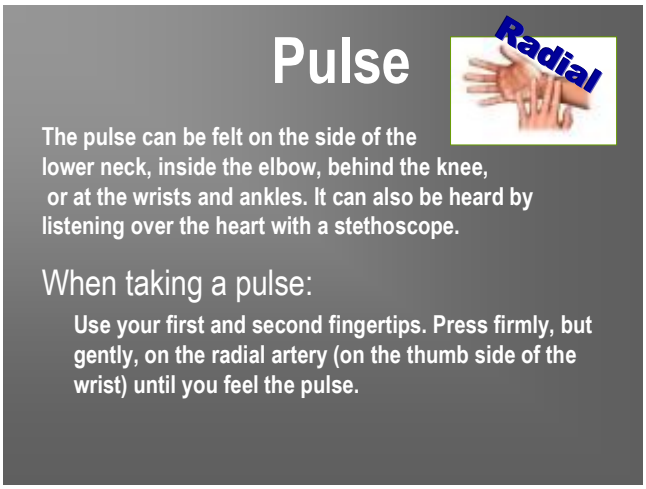
Note if pulse if regular or irregular. A client with a regular pulse has evenly spaced beats which may vary slightly. A regular irregular pulse rate has a regular pattern overall with 'skipped' beats. Some clients may present and irregularly irregular pulse rate which is chaotic, has no real pattern, and is very difficult to measure accurately.

How to check your pulse

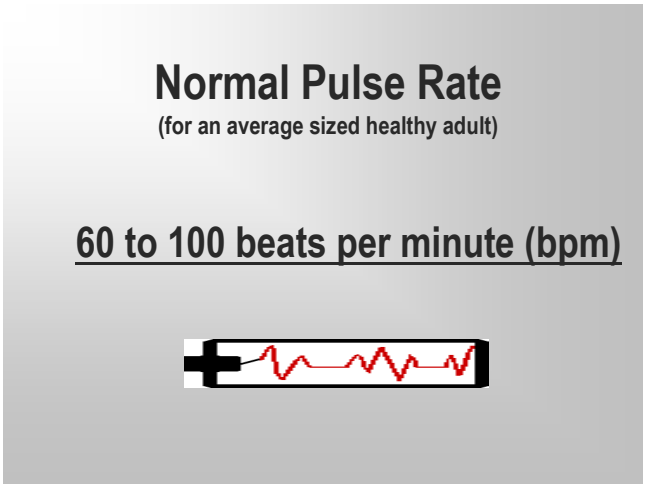
As the heart forces blood through the arteries, you feel the beats by firmly pressing on the arteries. The arteries are located close to the surface of the skin at certain points of the body. The pulse can be found on the side of your lower neck, on the inside of the elbow, or at the wrist. When taking your pulse:

⇒ Use the first and second fingertips, press firmly but gently on the arteries until you feel a pulse.
⇒ Begin counting the pulse when the clock's second hand is on the 12.
⇒ Count your pulse for either 60 seconds, or 15 seconds and multiply that by 4 to calculate beats per minute.
⇒ When counting, do not watch the clock continuously, but concentrate on the beats of the pulse rate.
⇒ If unsure about your results, ask another person to count for you.

If your physician has ordered you to check your own pulse and you are having difficulty finding it, consult your physician for additional instruction.



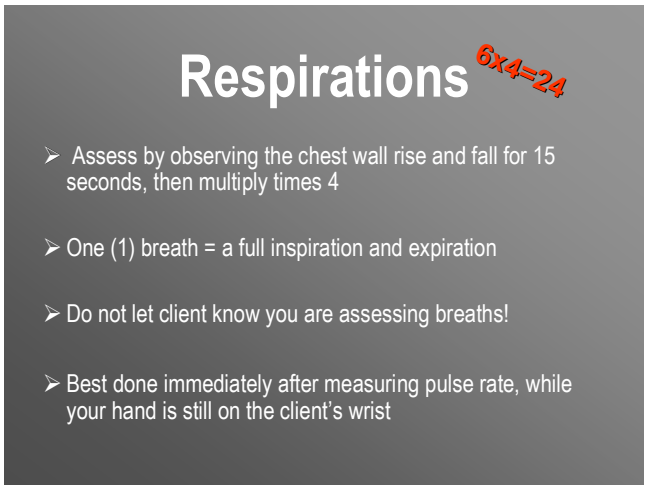
If a client's pulse is irregular:
Count for one full minute
Question client regarding any history of irregular pulse or cardiac problems
Record total in appropriate area on chart
Note description of irregularity in progress notes
Notify appropriate staff member



What is the respiration rate?

The respiration rate is the number of breaths a person takes per minute. Measuring the rate involves counting the number of breaths of a client for one minute by counting how many times the chest rises. Respiration rates may increase with fever, illness, and with other medical conditions. When checking respiration, it is important to also note whether a person has any difficulty breathing.

Normal respiration rates for an adult at rest range from 12-24 breaths per minute. Respiration rates over 25 breaths per minute (when at rest) may be considered abnormal.



Factors affecting respirations

- Chest wall pain—breaths are shallow
- Anemia—breaths become faster as the body attempts to get more oxygen to vital organs
- Activity—rate and depth increases to meet body's greater oxygen demand
- Acute pain—rate and depth increase as directed by the nervous system
- Anxiety
- Smoking
- Body position
- Medications
- Narcotic analgesics and sedatives
- Amphetamines and cocaine

What is blood pressure?

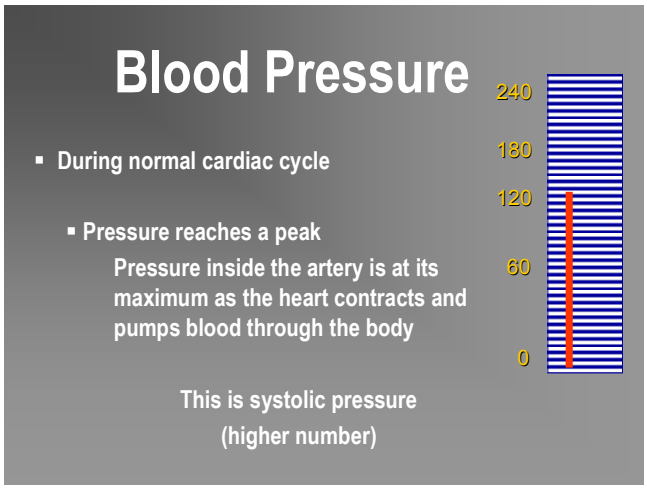
Blood pressure, measured with a blood pressure cuff and stethoscope by a nurse or other healthcare provider, is the force of the blood pushing against the artery walls. Each time the heart beats, it pumps blood into the arteries, resulting in the highest blood pressure as the heart contracts. One cannot take his own blood pressure unless an electronic blood pressure monitoring device is used. Electronic blood pressure monitors may also measure heart rate and/or pulse.

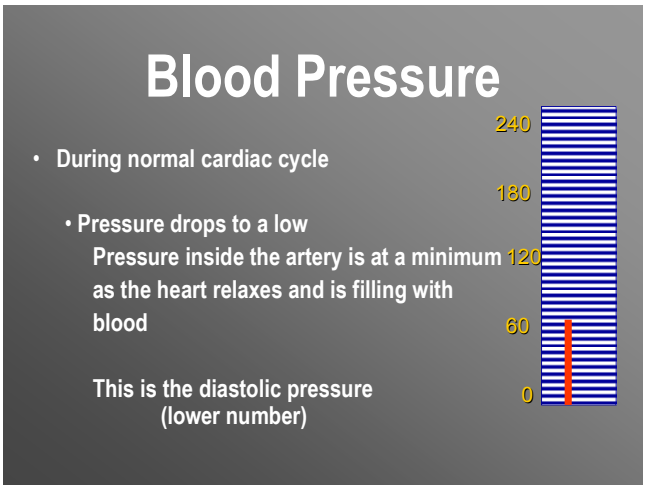
Two numbers are recorded when measuring blood pressure. The higher number, or systolic pressure, refers to the pressure inside the artery when the heart contracts and pumps blood through the body. The lower number, or diastolic pressure, refers to the pressure inside the artery when the heart is at rest and is filling with blood. Both the systolic and diastolic pressures are recorded as millimeters of mercury (mmHg). This recording represents how high the mercury column is raised by the pressure of the blood.

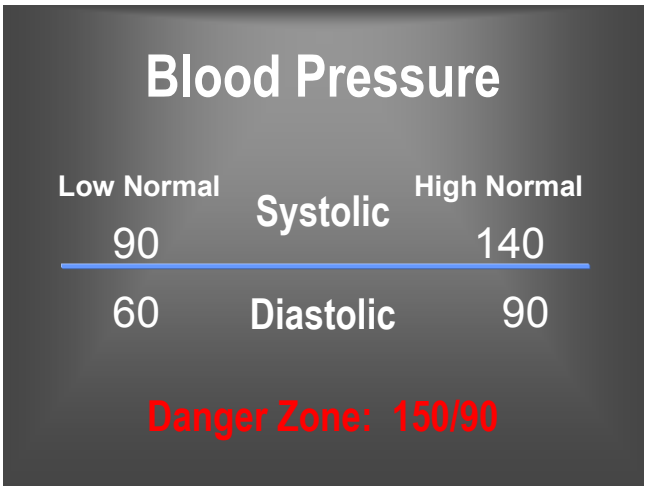
High blood pressure, or hypertension, directly increases the risk of coronary heart disease (heart attack), and stroke (brain attack). With high blood pressure, the arteries may have an increased resistance against the flow of blood, causing the heart to pump harder to circulate the blood. According to the American Heart Association, high blood pressure for adults is defined as:

⇒ 140 mmHg or greater systolic pressure and/or
⇒ 90 mmHg or greater diastolic pressure

These numbers should be used as a guide only. A single elevated blood pressure measurement is not necessarily an indication of a problem. Your physician will want to see multiple blood pressure measurements over several days or weeks before making a diagnosis of hypertension (high blood pressure) and initiating treatment. A person who normally runs a lower-than-usual blood pressure may be considered hypertensive with lower blood pressure measurements than 140-90.







Factors influencing blood pressure

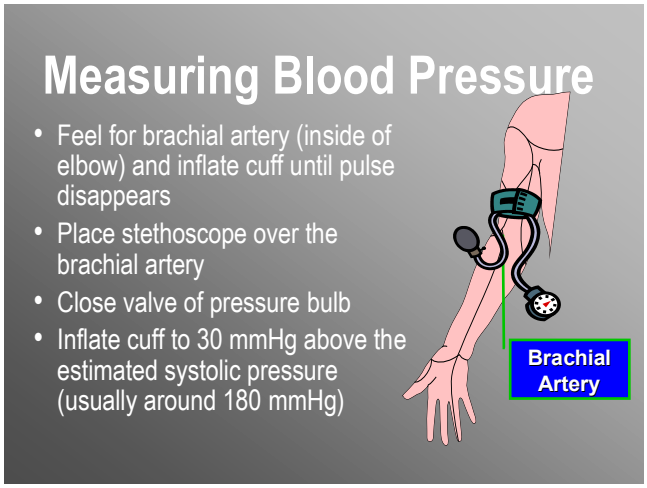
- Age
- Stress
- Gender
- Race
- Medications
- Time of day variation
- Hypertension

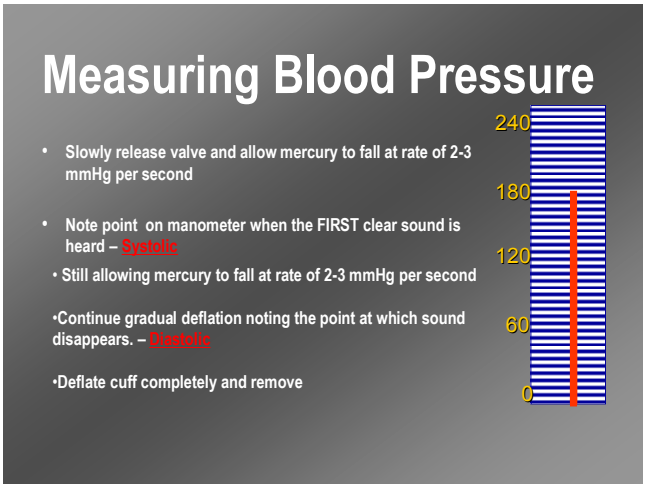
Measuring blood pressure

You will need:
- A quiet room with comfortable temperature
- 2 chairs (one for client, one for you)
- Stethoscope
- Sphygmomanometer (Blood pressure cuff)

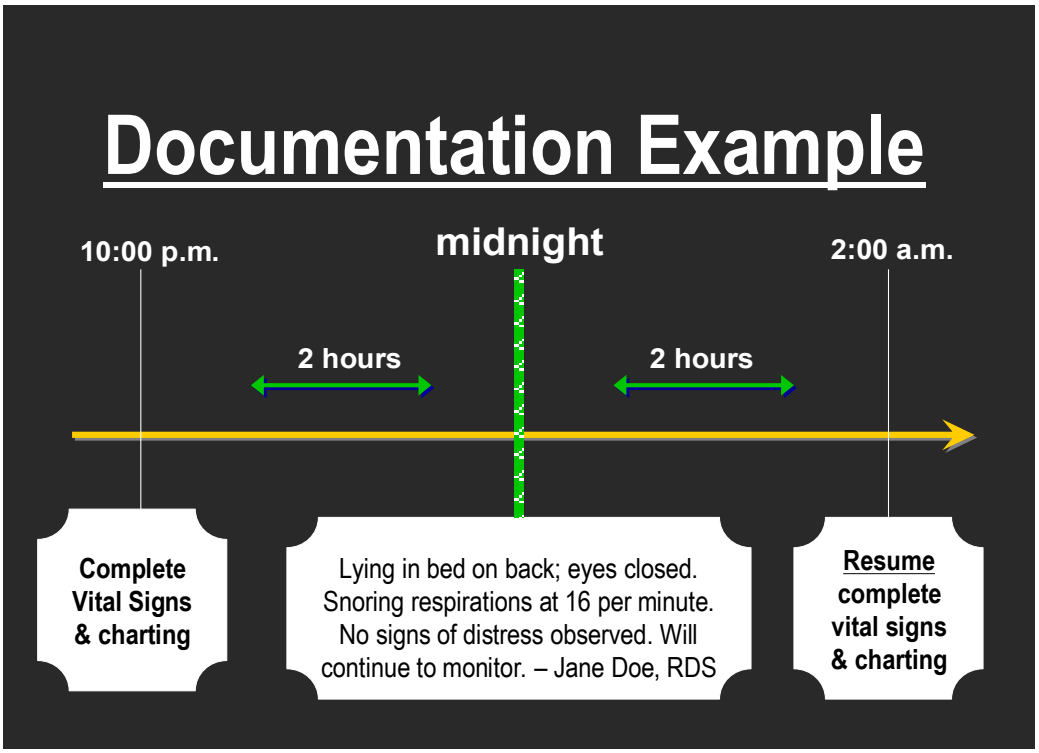
If client has, or believe client may have, smoked or participated in any physically exerting activities, have that client wait 30 minutes before measuring blood pressure. Ask client to sit down while you ready your equipment and wash your hands, this allows a few moments for pressure to level out.

Then, client should remove clothing from arm if it is restrictive. Client's arm should be positioned so the antecubital fold is level with the heart, and the arm should be supported on a table or bed if client is lying down. The cuff must be centered over the brachial artery, approximately 2 cm above the fold. Position client's arm so it is slightly flexed at elbow, applying the cuff around the arm evenly and snuggly. *Not tight- 2 fingers should slide under cuff" The bottom of the cuff should be 1 inch above the brachial pulse site.





Documentation




Drugs and Their Effects

Drug Categories

The Controlled Substances Act, passed by congress in 1970, places known drugs into five schedule categories due to their potential for physical or psychological affects, medical benefits, safety of use, and potential for abuse.

Schedule I substances are potentially the easiest to abuse and serve little to no medical purpose. Schedule I drugs are illegal and include: heroin, LSD, marijuana, MDA, MDMA, mescaline, peyote, PCP.

Schedule II substances are highly abused and have a huge potential for severe physical/psychological dependence. Schedule II drugs include: amphetamine, cocaine, codeine, methadone, methamphetamine, morphine, oxycodone.

Drugs under Schedule III may have a potential for mild physical or psychological addiction. Schedule III substances include: anabolic steroids, hydrocodone, testosterone.

Schedule IV substances have a potential for misuse or over use and include: chloral hydrate, diazepam, lorazepam, phentermine, propoxyphene, temazepam.

Schedule V drugs have a potentially low abuse rate alone, however, these substances are often used or mixed with more addictive drugs. Schedule V substances include: buprenorphine, codeine (mixed with non-narcotic medications), diphenoxylate.

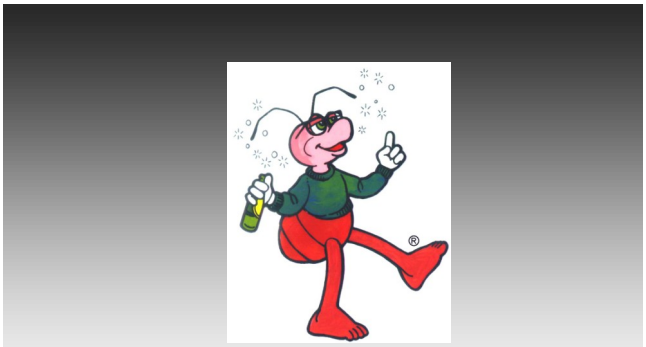
Addiction specialists and researchers categorize drugs and medications into groups such as *opioids, sedative-hypnotics,* and *stimulants.* Drugs in each group are similar pharmacologically and produce a similar withdrawal syndrome.

The term *opiate* refers to opium and derivatives of opium, a naturally occurring substance that has effects similar to those of morphine. Drugs such as heroin and medications such as codeine are examples of opiates. Examples of synthetic opioids include Demerol, Percodan, and methadone.

Sedative-hypnotics are usually prescribed medications designed to reduce anxiety or facilitate sleep. They include barbituates such as, secobarbital (Seconal), benzodiazepines such as: diazepam (Valium) and alprazolam (Xanax). Alcohol shares many pharmacological characteristics with the sedative-hypnotics.

Stimulants produce increased arousal accompanied by a sense of confidence and euphoria. This category of drug includes cocaine and methamphetamine.

The Three Ants were born on a late spring day in 1987. Their purpose was to help lay-people understand the basic pharmacology of psychoactive drugs. The name of the three ants describes the actions produced by each of three general groups of psychoactive drugs. The Three Ants thus, began as a helpful way for understanding the action of psychoactive drugs.



Depress-Ant® (depressant) drugs depress, or decrease thinking, feeling and behavior.

Depressants

Drugs which fall into this sector of substances produce central nervous system (CNS) depression. If prescribed, depressants are often used as sleeping aids, contain anti-anxiety properties, and help in relieving stress. While alcohol is one of the oldest known depressants, barbiturates and benzodiazepines have increased notably in abuse through prescribed and illegal means.

Barbiturates mirror the intoxication results similar to alcohol. Often individuals who become addicted experience a rapidly increasing tolerance, resulting in overdosing into coma or death.

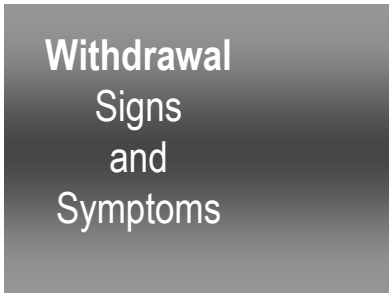
Benzodiazepines were first thought to have a lower addiction rate than barbiturates, and be much safer. However, the misuse or combining of other depressant substances with benzodiazepine can result in over-sedation and respiratory failure.

Included as depressants are: flunitrazepam (Rohypnol), fentanyal, Oxycontin, Percodan, Percocet, Demerol, meperdine, Dilaudid, Vicodin, Lortab, Lorcet, Darvocet.

Stim-U-Ant® (stimulant) drugs stimulate or increase thinking, feeling and behavior.

Confuse-Ant® drugs confuse or distort thinking, feeling and behavior.

Depress-Ant	Stim-U-Ant	Confuse-Ant
Alcohol	Tobacco	Marijuana
Barbiturates	Amphetamine	PCP
Benzodiazapines: Valium	Methamphetamine	LSD
	Cocaine	Ketamine
Narcotics: Heroin, Codeine, Oxycodone, Meperidine (Demerol)		MDMA: Ecstasy
		Inhalants



ALCOHOL

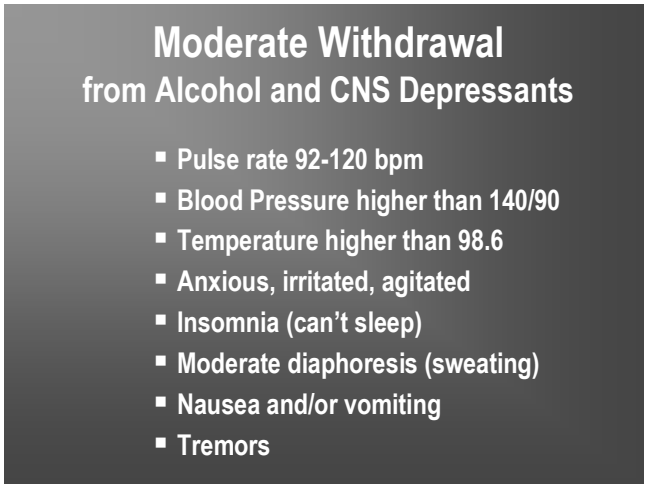
A client who has been drinking at least 16 oz. of 80 proof alcohol per day or the equivalent of a 6 pack a day will show some or all of the following signs of intoxication:

* Decreased coordination
* Slurred speech
* Vomiting
* Loss of consciousness
* Glassy eyes
* Slowed response
* Loss of inhibitions

Signs of Alcohol Poisoning:

* Seizures
* Abnormal respirations (Less than 10/minute, apnea possible)
* Hypothermia can result in heart stopping (Skin may be gray or blue tones, pale)
* Confusion, coma (Can't be aroused even with painful stimulus)

Anticipate withdrawal if a client has ingested (daily) prescribed sedative-hypnotics (tranquilizers), for over 6 months, in combination with other mind-altering chemicals (like alcohol). Withdrawal also occurs when a client has ingested (daily) sedative-hypnotics above the recommended dose for more than 4 weeks.



Interventions
Mild to Moderate Withdrawal
from Alcohol and CNS Depressants

- Place in observation detoxification
- Monitor VS every 2 hours
- Push Fluids (Juice) Diet as tolerated
- After stable, encourage client to sit up
- Limit noise (quiet environment)
- If medical problems arise, refer for medical services

Severe Withdrawal
(Life Threatening)
from Alcohol and CNS Depressants

- Pulse rate higher than 120 bpm
- Blood Pressure greater than 160/110
- Temperature over 100
- Confused
- Delirious
- Seizures
- Cardiovascular Collapse and death will result if not treated

REFER FOR MEDICAL SERVICES IMMEDIATELY!

Severe Withdrawal
from Alcohol and CNS Depressants

- A client is not safe if having tremors or confusion, they will need detoxification medication to bring their body systems back into the normal range, thereby, bringing them in the safety zone.
- If a client does not get relief with detoxification medications, they are probably either in major withdrawal or they have a tolerance to CNS depressants.

Severe Withdrawal
from Alcohol and CNS Depressants

- **Never allow a client to exceed a blood pressure of 160/110 and have tremors; This indicates…**

PRE-SEIZURE THRESHOLD!

Delirium Tremens

Delirium Tremens (DT's) can occur up to 24 days after the individual has last used alcohol. Clients with a history of DT's have an increased likelihood of having them again. Sign's of a person suffering from DT's are:

- Hallucinations: visual, auditory, olfactory, tactile
- Tremors: arms extended and fingers spread
- Disorientation: does not know one or more of the following, person, place, day, date
- Indistinct speech: vague, unclear
- Dilated pupils: large pupils
- Restlessness: wants to leave, pacing
- Irritable: short-tempered
- Rapid pulse: 90-160 bpm or higher
- Moist skin: clammy

INTERVENTION

for ALL alcohol abuse…

- **good nutrition**
- **plenty of fluids**
- **activity as permitted/tolerated**
- **NO ALCOHOL**

Narcotic Withdrawal

WARNING: Dehydration is a medical emergency!

During dehydration the pulse elevates as the blood pressure drops or remains close to the same.

FOLLOW EMERGENCY PROCEDURES AS OUTLINED IN YOUR FACILITY POLICY AND PROCEDURE MANUAL .

Mild Narcotic withdrawal Symptoms

- Goose bumps
- Muscle twitching
- Muscle and joint pain
- Abdominal discomfort
- Dilated pupils
- Anxiety

Interventions for Mild Narcotic withdrawal

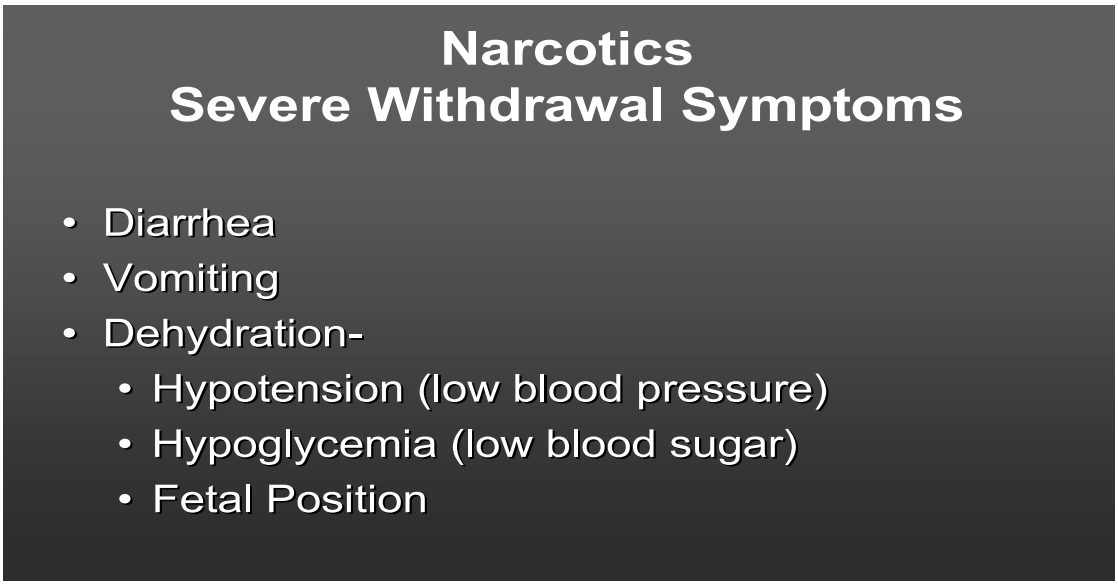
- Place in observation detoxification
- Monitor VS
- Bed rest
- Push fluids (juices)
- Diet as tolerated
- If medical problems arise, refer for medical services with the doctor or hospital of their choice

Narcotics
Moderate Withdrawal Symptoms

- **Pulse rate is greater than 92 bpm**
- **Blood pressure is higher than 140/90**
- **Temperature is 98-100.2**
- **Rhinitis (runny nose)**
- **Lacrimation (Watery eyes)**
- **Nausea**
- **Extreme restlessness**
- **Anorexia (no appetite)**

Interventions
for moderate Narcotic withdrawal

- **Place in observational detoxification.**
- **If medical problems arise, refer for medical services with the hospital or doctor of their choice.**



WARNING

Severe dehydration is a medical emergency requiring advanced medical care!

Symptoms of Dehydration

- Thirst
- Dry lips
- Dry mouth
- Flushed skin
- Fatigue
- Irritability
- Headache
- Darkened urine
- Urine output decreases

SEVERE DEHYDRATION

- Dehydration occurs when the body does not have enough fluids to carry out its normal functions
- Intravenous fluids and hospitalization may be required
- Severe dehydration is a medical emergency
- Consult with medical personnel immediately
- Symptoms: blue lips, blotchy skin, confusion, cold hands and feet, rapid breathing, rapid and weak pulse, low blood pressure, dizziness, fainting, high fever, inability to urinate or cry tears, disinterest in drinking fluids

Narcotic Withdrawal

WARNING: Dehydration is a medical emergency!

During dehydration the pulse elevates as the blood pressure drops or remains close to the same.

FOLLOW EMERGENCY PROCEDURES AS OUTLINED IN YOUR FACILITY POLICY AND PROCEDURE MANUAL .

Interventions for severe narcotic withdrawal

Refer immediately for medical attention to doctor or hospital of their choice.

Stimulants
Mild Withdrawal Symptoms

- Initially – anxiety
- Lack of energy
- Increased appetite

Stimulants
Mild withdrawal Symptoms

- Hyper-somnolence (very deep sleep)
- Intense drug craving
- Muscle aches
- Abdominal pain
- Profound depression (severe)

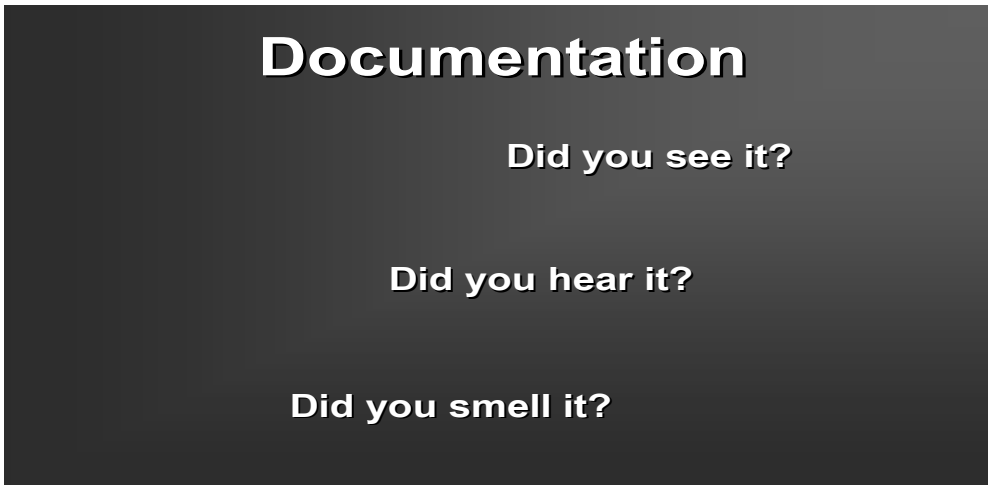
Interventions for mild stimulant withdrawal

- Place in observation detoxification
- Monitor VS
- Bed rest
- Push fluids (juices)
- Diet as tolerated
- If medical problems arise, refer for medical services

Interventions for Moderate to Severe Stimulant Withdrawal

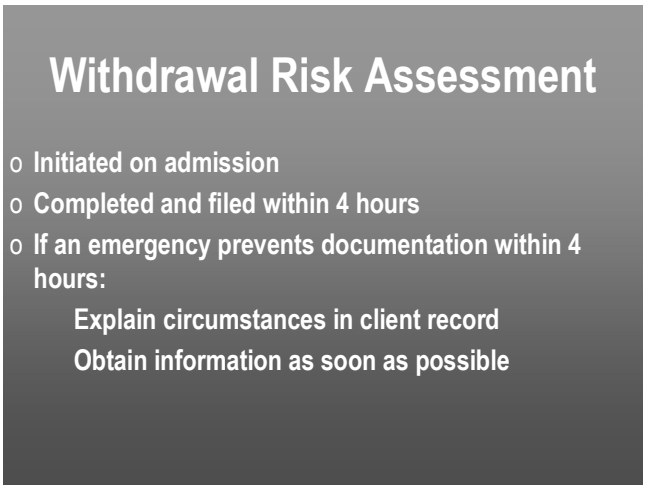
- Place in observational detoxification
- Monitor VS
- Bed Rest
- Push Fluids (Juices)
- Diet as tolerated

If medical problems arise or profound depression occurs, refer for medical services



A file containing the following information on every client per each admission

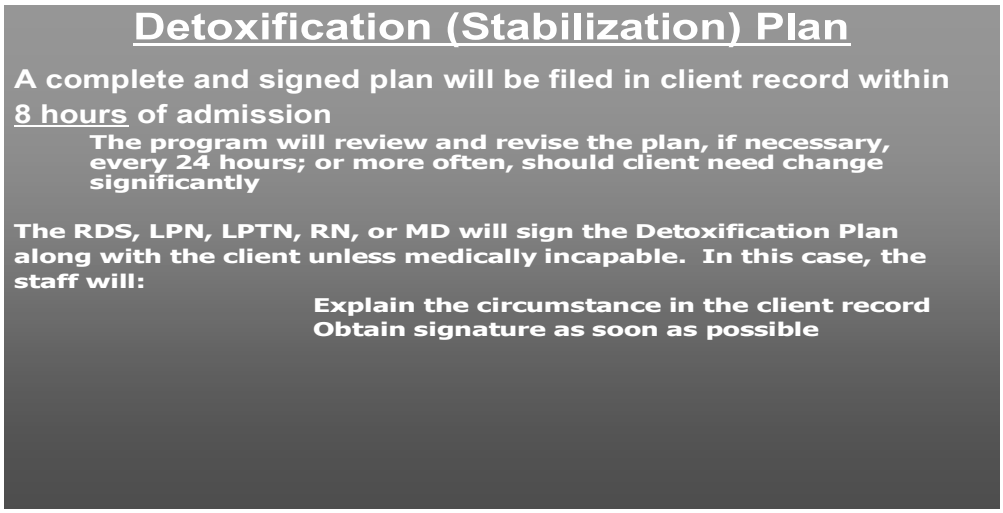
- Proof of client identity (i.e. copy of drivers license)
- A signed Voluntary Admission Agreement or Court Order
- Conditions of Admission Agreement
- Financial Risk Assessment
- Authorizations for Release of Information
- Personal Property Inventory (signed by client)
- Detoxification (Stabilization) Plan
- Aftercare (Discharge) Plan
- RDS (Progress) Notes
- Vital Signs Sheet



A qualified staff member will perform the **Withdrawal Risk Assessment.**

It will include:

- Substance abuse history
- Current detoxification level determination
- Past psychiatric treatment
- Past AOD treatment
- Significant medical history
- Current health status
- Current medications
- Known food and drug allergies
- Current living and employment situation
- Current emotional state and behavioral functioning



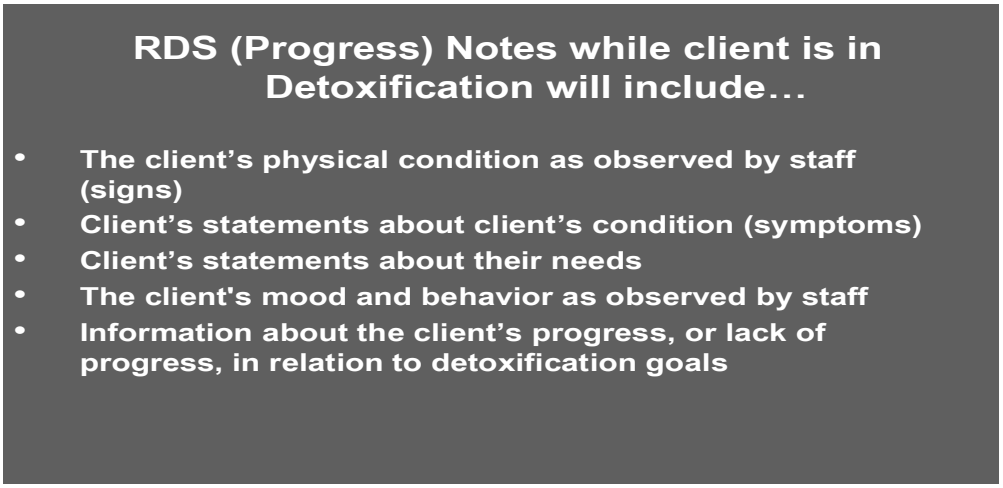
Completed and Signed

* Authorization (s) to release confidential information, as appropriate

- Personal property inventory signed by staff or authorized agent, and client

(* Note * To avoid liability, use general terms to describes valuables such as: 'ring with yellow band and white stone,' instead of 'diamond ring')

- Vital Signs Sheet: VS documented every 2 hours until stable or within normal limits for 8 hours; additional noted will be documented as appropriate



- RDS Notes: The use of abstract terms, technical jargon and slang are to be avoided in the progress notes and in treatment plans
- After/Discharge Plan will include: Aftercare Plan, Clients needs, Goals, Objectives, and Target dates

Documentation

- Document BEFORE LEAVING!
- Do not document tomorrow.
- Do not let someone else document for you.
- Do not place copies of your original documentation in a file.

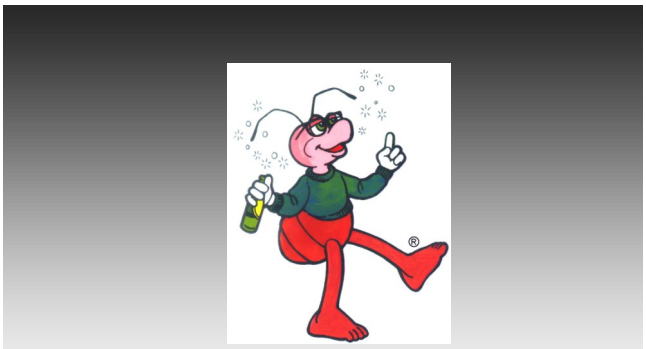
On-going monitoring…

Will be documented at least every 2 hours, after Initial intake, until…

Client is experiencing symptoms no higher than mild withdrawal for 8 hours and

Vital signs are within normal limits for 8 hours

DRUGS, SIDE EFFECTS, and WITHDRAWAL SYMPTOMS



Depress-Ant® (depressant) drugs depress, or decrease thinking, feeling and behavior.

COMMON ABUSED DRUGS	COMMON STREET NAMES
Alcohol	Booze, Fire Water, Liquid Courage, On the Turps, Sauce
Ambien (Zolpidem)	Chill Pills, Downers, Tic-Tacs
Aquachloral (Chloral Hydrate)	Coral, Knockout Drops, Mickeys,
Cannabis	Broccoli, Cheeba, Funk, MJ, Spliff, Stuff, Time
Codeine (Methalmorphine)	AC/DC, Nods, Schoolboy, T3
Darvocet	
Febtanyl	
GHB (Gammahydroxybutyrate)	Battery Acid, Date Rape Drug, Cherry Meth, Easy Lay, Liquid X, Scoop
Hydrocodone (Lorcet, Lortab, Vicodin)	Vikes
Hydromorphone (Dilaudid)	Dillies,
Lorazepam (Ativan)	
Meperidine (Demerol)	Bam,
Meprobamate (Soma)	
Methadone (Dolophinel, Physeptone)	Doses, Juice, Phy
Methaqualone	714's, Ludes
Morphine	
Opium	
Oxycodone	Beans, OC, Rushbo
Oxycontin	
Percocet	
Rohypnol	Circles, Le Roche, Roaches, Ruffies,
Thebaine	
Valium	Blue Angels, Mother's Little Helper, Vallies,
Ultram	
Xanax (Alprazolam)	Bars, Coffins, Dogbones, Totem Poles, Zannies

ALCOHOL SIDE EFFECTS

Alcohol is often not thought of as a drug – largely because its use is common for both religious and social purposes in most parts of the world. It is a drug, however, and compulsive drinking in excess has become one of modern society's most serious problems.

Alcohol side effects include, but are not limited to:

General Effects

Alcohol is a DOWNER that reduces activity in the central nervous system. The alcohol intoxicated person exhibits loose muscle tone, loss of fine motor coordination, and often has a staggering "drunken" gait.

Eyes

The eyes appear somewhat "glossy" and pupils may be slow to respond to stimulus. At high doses, pupils may become constricted.

Vital Signs

At intoxicating doses, alcohol can decrease heart rate, lower blood pressure and respiration rate, and result in decreased reflex responses and slower reaction times.

Skin

Skin may appear cool to the touch (but the user may feel warm), profuse sweating may accompany alcohol use.

Alcohol Withdrawal

People who drink alcohol on a regular basis become tolerant to many of the unpleasant side effects, and thus are able to drink more before suffering these effects. Yet, even with increased consumption, many such drinkers don't appear intoxicated. They continue to work and socialize reasonably well, and their deteriorating physical condition may go unrecognized by others until severe damage develops – or until they are hospitalized for other reasons and suddenly experience alcohol withdrawal symptoms.

Psychological addiction to alcohol may occur with regular use even if only consumed in relatively moderate, daily amounts. It may also occur in people who consume alcohol only under certain conditions, such as, before and during social occasions. This form of addiction refers to a craving for alcohol's psychological effects, although not necessarily in amounts that produce serious intoxication. For psychologically addicted drinkers, the lack of alcohol tends to make them anxious and, in some cases, panicky.

Physical addictions to alcohol occur in consistently heavy drinkers. Since their bodies have adapted to the presence of alcohol, they suffer alcohol withdrawal when alcohol consumption is suddenly stopped. The signs and symptoms of acute alcohol abstinence generally begin 6 to 24 hours after patient takes his or her last drink. The acute phase of alcohol abstinence may begin when the patient still has significant blood alcohol concentrations.

Most alcohol-dependent individuals can be detoxified in a modified medical setting, provided assessment is comprehensive, medical backup is available, and staff know when to obtain a medical consultation. Patients who score higher than 20 on the Clinical Institute Withdrawal Assessment (CIWA-Ar) should be admitted to the hospital.

Most patients can be detoxified from alcohol in 3 to 5 days. Providers should consider the withdrawal time frame in terms of when the patient will need the most support; for alcoholics, this occurs the second day after the last ingestion. Other factors that influence the length of the detoxification period include the severity of the dependence and the patient's overall health. Patients who are medically debilitated should detoxify more slowly.

Regional Alcohol and Drug Detoxification

Alcohol withdrawal symptoms include, but are not limited to:

- Sweating
- Rapid pulse, jumpiness
- Increased hand tremor or “the shakes”
- Insomnia, sleeplessness
- Poor appetite, nausea or vomiting
- Physical agitation
- Transient visual, tactile, or auditory hallucinations, illusions
- Convulsion, Grand Mal Seizures
- Death

Ambien Side Effects

Ambien with the generic name of Zolpidem, belongs to a class of medicines that effect the central nervous system called, sedative hypnotics. Ambien is closely related to a family of drugs called benzodiazepines. These drugs cause sedation, muscle relaxation, act as anti-convulsants (anti-seizure), and have anti-anxiety properties. Ambien addiction and abuse affects numerous individuals who experience withdrawal symptoms after continued, abuse from unintentional addiction.

Ambien side effects include, but are not limited to:

- Abdominal pain, abnormal dreams, abnormal vision, agitation, amnesia, anxiety, arthritis
- Back pain, bronchitis, burning sensation
- Chest pain, confusion, constipation, coughing
- Daytime sleeping, decreased mental alertness, depression, diarrhea, difficulty breathing, difficulty concentrating, difficulty swallowing, diminished sensitivity to touch, dizziness on standing, double vision, dry mouth
- Emotional instability, exaggerated feeling of well-being, eye irritation
- Falling, fatigue, fever, flu-like symptoms
- Gas, general discomfort
- Hallucination, hiccup, high blood pressure, high blood sugar
- Increased sweating, infection, insomnia, itching
- Joint pain
- Lack of bladder control, lack of coordination, lethargy, light-headedness, loss of appetite
- Menstrual disorder, migraine, muscle pain
- Nasal inflammation, nervousness, numbness
- Paleness, prickling or tingling sensation
- Rapid heartbeat, rash, ringing in ears
- Sinus inflammation, sleep disorder, speech difficulties, swelling due to fluid retention
- Taste abnormalities, throat inflammation, throbbing heartbeat, tremor
- Unconsciousness. Upper respiratory infection, urinary infection
- Vertigo, vomiting
- Weakness

Ambien Withdrawal

Ambien has a selectivity in that it has little of the muscle relaxant or anti-seizure effect and more of the sedative effect. Therefore, it is used as a medication for sleep. Addiction to ambient can occur with regular use for an extended amount of time. Once discontinued, ambient withdrawal symptoms arise. This creates a vicious cycle, the user has the desire to quit using of Ambien, but the withdrawal symptoms may be even worse than before the first time they used.

Ambien withdrawal symptoms include, but are not limited to:

- Abnormal extroversion or aggressive behavior, anxiety, agitation
- Loss of personal identity, suicidal thoughts, depression
- Confusion, hallucinations, insomnia

Ativan Side Effects

Ativan is the brand name for Lorazepan, an anti-anxiety agent. Avitan is a benzodiazepine and mild tranquilizer, sedative, and central nervous system (CNS) depressant. Ativan is manufactured in pill form as well as liquid form for injection. There are many side effects that come with the use and abuse of Ativan.

Ativan side effects include, but are not limited to:

- Clumsiness, Unsteadiness, weakness
- Dizziness, disorientation, depression, drowsiness, disinhibition (inappropriate, grandiose or out-of-control behavior)
- Sleepiness, insomnia
- Amnesia, agitation, abdominal discomfort, antergrade amnesia (decreased or lack of recall of events), acute amnesia, memory functioning markedly and measurably impaired, inability to store acquired knowledge into long-term memory
- Headache
- Visual problems, blurred vision
- Nausea
- Tachycardia

Memory impairment is highly relevant in students. The risk of acute amnesia is more pronounced with short-acting drugs. Ativan (lorazepam), halcyon (triazolam), Xanax (alprazolam) and rohypnol (flunitrazepam) are especially likely to induce such memory impairment.

Ativan, if injected, side effects include, but are not limited to:

- Increased sedation
- Hallucination, irrational behavior
- Leucopenia
- Elevated and decreased blood sugar levels

Ativan Withdrawal

Ativan is the brand for Lorazepam, an anti=anxiety agent. Avitan is a benzodiazepine and mild tranquilizer, sedative, and central nervous system (CNS) depressant. Ativan is very addictive. Ativan can cause psychological and physical addiction. Individuals develop an addiction to Ativan because it produces feelings of well-being. Once an individual has developed an addiction to Ativan, they will often get multiple prescriptions from different doctors to support their addiction. Ativan activates the brain's reward systems. The promise of reward is very intense, causing the individual to crave more Ativan and to focus his or her activities around taking the drug. The ability of Ativan to strongly activate brain reward mechanisms, and its ability to chemically alter the normal functioning of these systems, is what produces an addiction to Ativan. Ativan also reduces a person's level of consciousness, harming the ability to think or be fully aware of present surroundings.

Withdrawal symptoms, similar in character to those noted with barbiturates and alcohol, have occurred following abrupt discontinuance of Ativan. The more severe withdrawal symptoms have usually been limited to those patients who received excessive doses over an extended period of time.

Ativan withdrawal symptoms include, but are not limited to:

- Abdominal and muscle cramps
- Convulsions
- Insomnia
- Nausea
- Ringing in the ears
- Shaking
- Tremors
- Vomiting

Codeine Side Effects

Codeine is an opiate agonist—sedative and analgesic narcotic substance found in opium concentrations between 0.1% and 2%. Codeine was first isolated from opium by the French chemist Pierre-Jean Robiquist in 1832. Because of the small concentration found in nature, most codeine found in medical products is synthesized from morphine. Codeine is a member of the drug class opiates. Opiates include: all naturally occurring drugs with morphine-like effects such as, codeine; all semi– and fully synthetic drugs with morphing-like effects such as, heroin and meperidine (Demerol). Addiction is a major risk with prolonged use (over 2-3 weeks) of codeine.

Codeine induces as "opiod analgesia" by altering the perception of pain at the spinal cord and brain. It also affects emotional responses to pain. Codeine has stimulating effects as well because it blocks inhibitory neurostransmitters. Repeated use of codeine can cause long-term changes in the way the nervous system functions.

Codeine side effects include, but are not limited to:

- Agitation
- Blurred vision, tiny pupils
- Constipation
- Depression
- Disorientation, hallucinations
- Hangover
- Impair ability to drive
- "Itchies"
- Kidney damage
- Liver damage
- Lowered heart rate, blood pressure and breathing
- Nausea
- Sexual problems
- Stomach bleeding
- Tremors, convulsions, seizures

Codeine Withdrawal

Being an opiate, codeine has the potential for addiction. It causes tolerance and physical addiction with chronic abuse. Clearly the properties possessed by codeine have or are fast becoming common knowledge amongst those abusing the drug. The worst codeine withdrawal symptoms pass within a few days, but it can take months to feel normal.

Codeine withdrawal symptoms include, but are not limited to:

- Dehydration
- Fever
- Headaches
- High blood pressure
- Insomnia
- Irregular heartbeat
- Muscle twitching, muscle pain
- Nausea, vomiting, stomach cramps
- Runny nose
- Sweating
- Weakness
- Yawning

Darvocet Side Effects

Structurally, Darvocet is a relative of the synthetic narcotic methadone. It's prescribed in two forms—propoxyphene hydrochloride and propoxyphene napsylate—for relief of mild to moderate pain. Darvocet produces psychological and physical dependence like other narcotics, and Darvocet addiction is much the same.

Darvocet side effects include, but are not limited to:

Common Side Effects

- Constipation
- Dizziness
- Drowsiness
- Lightheadedness
- Nausea or vomiting
- Shortness of breath

Less Common to Rare Side Effects

- Confusion
- Difficulty urinating
- Euphoria (feeling of unusual happiness)
- Hallucinations
- Low blood pressure
- Over excitement
- Skin rash, hives or itching, red dots on skin
- Stomach pain

Life-threatening Side Effects

- Difficulty breathing
- Heart palpitations
- Wheezing

Darvocet Withdrawal

Given Darvocet's similarities to methadone, it's not surprising that Darvocet is as addictive as it is. Individuals develop an addiction to Darvocet because it produces feelings of well-being. Once an individual has developed an addiction to Darvocet they will often get multiple prescriptions from different doctors to support their addiction. Darvocet activates the brain's reward systems. The promise of reward is very intense, causing the individual to crave more Darvocet and to focus his or her activities around taking the drug. The ability of Darvocet to strongly activate brain reward mechanisms and its ability to chemically alter the normal functioning of these systems is what produces an addiction to Darvocet. Darvocet also reduces a person's level of consciousness, harming the ability to think or be fully aware of present surroundings.

Darvocet withdrawal symptoms include, but are not limited to:

- Anxiety, fatigue
- Nausea, loss of appetite and weight, diarrhea
- Physical craving

Demerol Side Effects

Demerol is a narcotic analgesic with effects similar to morphine. The most prominent effect involves the central nervous system and organs composed of smooth muscle. When prescribed, it is used for relief of moderate to severe pain. Demerol is addictive. When the user repeatedly uses Demerol, they build a tolerance to the drug and this creates both a mental and physical addiction.

An allergic reaction to Demerol includes such effects as: Pruritus, Urticaria, and other skin rashes

Demerol side effects include, but are not limited to:

- Agitation
- Biliary tract spasm
- Bradycardia
- Cardiac arrest
- Circulatory depression
- Constipation
- Dry mouth
- Dysphasia
- Euphoria
- Headache
- Hypotension
- Lightheadedness, dizziness
- Nausea or vomiting
- Palpitations
- Pruritus, Urticaria, and other skin rashes
- Respiratory depression. Respiratory arrest
- Shock
- Sedation
- Severe convulsions, tremor
- Sweating, flushing of the face
- Tachycardia
- Transient hallucinations and disorientation, visual disturbances
- Weakness, uncoordinated muscle movements

Demerol Withdrawal

When an individual becomes addicted to Demerol, they can no longer function without it. Demerol addiction is devastating not only to the individual physically, but emotionally as well. Demerol withdrawal symptoms can occur 4-5 hours after the last dose. Demerol withdrawal symptoms usually last 7-10 days. Individuals who are unaware they have Demerol addiction may respond to the pain of withdrawal by taking another dose of Demerol.

Demerol withdrawal symptoms include, but are not limited to:

- Insomnia
- Muscle spasms, tremors
- Profuse sweating, chills, shivering
- Severe anxiety
- Urinary retention

Dilaudid Side Effects

Dilaudid is an analgesic narcotic with an addiction liability to that of morphine. It is apparent within 15 minutes and remains in effect for more than five hours. Dilaudid is approximately 8 times more potent, on milligram basis, than morphine. Often called "drug store heroin," Dilaudid inhibits ascending pain pathways in the central nervous system. It also increases the pain threshold and alters pain perception. Dilaudid is a very addictive narcotic. Individuals can form an addiction to Dilaudid within days. Dilaudid side effects vary in intensity from person to person, and are not usually life threatening.

Dilaudid side effects include, but are not limited to:

- Anxiety, fear
- Constipation, inability to urinate
- Dizziness
- Impairment of mental and physical performance, mental clouding
- Mood changes
- Nausea or vomiting
- Restlessness
- Sedation
- Troubled and slowed breathing

Less common side effects include, but are not limited to:

- Agitation
- Blurred vision
- Chills, Cramps
- Diarrhea, difficulty urinating, disorientation, dry mouth, disorientation, double vision
- Exaggerated feeling of depression or well-being
- Failure of breathing or heartbeat, faintness/fainting, flushing
- Hallucinations, headache, high or low blood pressure
- Increased pressure in the head, insomnia, involuntary eye movement, itching
- Loss of appetite, light-headedness
- Muscle rigidity or tremor
- Muscle spasm of the throat or air passages
- Palpitations
- Shock, slow or rapid heartbeat, sudden dizziness on standing, sweating, small pupils
- Tingling and/or numbness, Taste changes
- Visual disturbances and weakness
- Uncoordinated muscle movement

Dilaudid Withdrawal

Dilaudid addiction is common place in today's society and can happen to anyone. Individuals who have formed an addiction to Dilaudid, use most often for a legitimate ailment and the individual becomes addicted. When individuals who have an addiction to Dilaudid are unable to get legitimate prescriptions, they may resort to what is called doctor shopping. The addict will see many doctors and pretend to be sick to obtain prescriptions. Individuals sometimes become addicted by someone turning them onto Dilaudid and enjoy the effects. Withdrawal symptoms can occur 4-5 hours after the last dose, and continue for 7-10 days. Users may respond to the pain of Dilaudid withdrawal by taking another dose without realizing they've become addicted.

Dilaudid withdrawal symptoms include, but are not limited to:

- Abdominal, leg and muscle cramps and pains
- Anorexia
- Chills, shivering, tremors, restlessness
- Diarrhea, intestinal spasm
- Gooseflesh
- Hot and cold flashes
- Increase in body temperature, blood pressure, respiratory rate, and heart rate, Insomnia, restless sleep
- Muscle spasms, twitching, severe backache
- Nausea or vomiting
- Profuse sweating
- Repetitive sneezing
- Severe anxiety and irritability
- Weakness, yawning

Hydrocodone Side Effects

Hydrocodone is an effective antitussive (anti-cough) agent. As an opiate, it is also an effective analgesic for mild to moderate pain control. 5 mg of hydrocodone is equivalent to 30 mg of codeine when administered orally. Early comparisons concluded that hydrocodone and morphine were equivalent for pain control in humans. However, it is now considered that
15 mg (1/4 gr) of hydrocodone is equivalent to 10 mg (1/6 gr) of morphine. Hydrocodone is considered to be morphine-like in all respects.

Hydrocodone abuse is an increasing trend in non-chronic pain suffering persons. Abuser's have been shown not to be the famous actor, a suburban real estate agent, or your next door neighbor. First time abuse of these drugs has been surging, most commonly with the oxycodone and hydrocodone type painkillers. The two differ slightly in their chemical makeup, but have similar effect on the body.

- Anxiety, fear, mood changes
- Constipation
- Decreased mental & physical performance, mental clouding
- Difficulty breathing
- Difficult urination
- Dizziness
- Drowsiness
- Dry throat
- Emotional dependence
- Exaggerated feeling of depression
- Extreme calm (sedation), exaggerated sense of well-being
- Itching
- Nausea or vomiting
- Restlessness, sluggishness
- Tightness in chest

Hydrocodone Withdrawal

Hydrocodone is a narcotic that can produce a calm, euphoric state similar to heroin or morphine. Despite such important and obvious benefits in pain relief, evidence is pointing to chronic addiction. Pure Hydrocodone is a Schedule II substance, closely controlled with restricted use. But, very few prescription drugs are pure Hydrocodone. Instead, small amounts of Hydrocodone are mixed with other non-narcotic ingredients to create medications like Vicodin and Lortab. This means they can be classified under Schedule III with fewer restrictions on their use and distribution.

Subject to individual tolerance, many medical experts believe dependence or addiction can occur within 1-4 weeks at higher doses of Hydrocodone. Published reports of high profile movie stars, TV personalities and professional athletes who are recovering from Hydrocodone addiction are grim testimony to its debilitating effects.

If a regular Hydrocodone user stops taking Hydrocodone, he or she will experience withdrawal symptoms within 6-12 hours but, the withdrawal symptoms are usually not life-threatening. The intensity of Hydrocodone withdrawal symptoms depend on the degree of the addiction. For example, hydrocodone withdrawal symptoms may grow stronger for 24-72 hours, then gradually decline over a period of 7-14 days. The duration of hydrocodone withdrawal symptoms varies from person to person.

Hydrocodone withdrawal symptoms include, but are not limited to:

- Intense cravings for the drug
- Irritability
- Nausea or vomiting
- Muscle aches
- Runny nose or eyes
- Dilated pupils
- Sweating
- Diarrhea
- Yawning
- Fevers
- Chills
- Inability to sleep
- Depression

Lortab Side Effects

Lortab combines a narcotic analgesic (painkiller) and cough reliever with a non-narcotic analgesic for the relief of moderate to moderately severe pain. Individuals become dependent upon Lortab for a feeling of well-being and will often get multiple prescriptions from different doctors to support their addiction.

Lortab side effects include, but are not limited to:

- Allergic reaction
- Anxiety, fear, mood changes
- Blood disorders
- Constipation
- Difficulty urinating
- Dizziness or lightheadedness, decreased mental and physical capabilities
- Drowsiness, unusual fatigue or weakness, sluggishness
- Hearing loss
- Itching
- Mental clouding
- Restlessness
- Slowed breathing
- Pinpoint pupils

Lortab Withdrawal

Lortab activates the brain's reward system. The promise of reward is very intense, causing the individual to crave more and focus his or her activities around taking the drug. The ability of Lortab to strongly activate brain reward mechanisms and it's ability to chemically alter the normal functioning of these systems, is what produces an addiction. Lortab also reduces a person's level of consciousness, harming the ability to think or be fully aware of present surroundings.

If a regular user of Lortab stops usage, he or she will experience Lortab withdrawal symptoms within 6-12 hours. Lortab withdrawal symptoms are usually not life-threatening, however the intensity of withdrawal symptoms depends on the degree of the individual's addiction. For example, Lortab withdrawal symptoms can grow stronger for 24-72 hours and then gradually decline over a period of 7-14 days.

Lortab withdrawal symptoms include, but are not limited to:

- Diarrhea
- Irritability
- Muscle aches
- Nausea or vomiting
- Runny nose or eyes, dilated pupils
- Sweating
- Yawning

Meth Side Effects

Methamphetamine is a stimulant drug chemically related to amphetamine but with stronger effects on the central nervous system. Street names for the drug include: speed, meth, crystal, and crank. Methamphetamine is used in pill form, or in powdered form by snorting or injecting. Crystallized methamphetamine, known as "ice," "crystal;" or "glass," is a smoke-able and more powerful form of the drug. Methamphetamine use has spread to all areas of the United States and continues to be on an upswing. Estimates from the Drug Abuse Warning Network (DAWN), indicate that methamphetamine-related emergency room episodes increased 346% from 1991 to 1995.

Physiological effects of methamphetamine use include:

- Abnormally high blood pressure
- Rapid and irregular heart rate and rhythm
- Damage to brain blood vessels (stroke)
- Excessive fluid in lungs, brain tissue, and skull
- Continuous/excessive dilation of pupils
- Impaired regulation of heat loss
- Hyperpyrexia (body temperatures higher than 104°)
- Internal bleeding
- Damage to other organs caused by disruptive blood flow
- Breakdown of muscle tissue leading to kidney failure
- Damage to lung and nasal passages
- AIDS

Meth side effects include, but are not limited to:

- Hyperactivity
- Irritability, aggression
- Visual hallucinations (hearing "voices")
- Suicidal tendencies, paranoid delusions, suspiciousness, severe paranois
- Shortness of breath
- Increased blood pressure
- Cardiac arrhythmia
- Stroke
- Sweating
- Nausea, vomiting, diarrhea
- Long periods of sleep ("crashing for 24-48 hours)
- Prolonged sluggishness, severe depression
- Weight loss, malnutrition, anorexia
- Itching (illusion of bugs on skin), welts on skin
- Involuntary body movements

Meth Withdrawal

Methamphetamine is a stimulant drug chemically related to amphetamine but with stronger effects on the central nervous system. Street names for the drug include: speed, meth, crystal, and crank. Methamphetamine is used in pill form, or in powdered form by snorting or injecting. Crystallized methamphetamine, known as "ice," "crystal;" or "glass," is a smoke-able and more powerful form of the drug.
Methamphetamine addiction has 3 patterns: low intensity, binge, and high intensity. Low intensity addiction describes a user who does not have psychological addiction to the meth, but uses methamphetamine on a casual basis by swallowing or snorting it. Binge and high intensity abusers have a psychological addiction to meth and prefer to smoke or inject methamphetamine to achieve a faster and stronger high. Binge abusers use methamphetamine more than individuals with low intensity meth addiction but less than individuals with a high intensity meth addiction.

Meth withdrawal symptoms include, but are not limited to:

- Fatigue, moderate to severe depression
- Long, disturbed periods of sleep
- Irritability, anxiety
- Intense hunger
- Psychotic reactions

Meth withdrawal, length and severity of depression is related to how much and how often meth was used. Withdrawal symptoms including: cravings, exhaustion, depression, mental confusion, restlessness, insomnia, deep or disturbed sleep, may last up to 48 hours.

Methadone Side Effects

Methadone is a (synthetic opiate) narcotic that when administered orally once a day, in adequate doses, can usually suppress a heroin addict's craving and withdrawal for 24 hours. Patients are as physically dependent on methadone as they were to heroin or other opiates, such as Oxy-Contin or Vicodin.

Methadone side effects include, but are not limited to:

- Drowsiness
- Lightheadedness
- Weakness
- Euphoria
- Dry mouth
- Urinary retention
- Constipation
- Slow or troubled breathing

Methadone side effects that are rare include, but are not limited to:

- Allergic reactions, skin rash, itching, facial flushing
- Headache
- Dizziness
- Impaired concentration, confusion
- Sensation of drunkenness
- Depression
- Blurred or double vision
- Sweating
- Heart palpitation
- Nausea or vomiting

Methadone side effects that are more uncommon include but are not limited to:

- Anaphylactic reactions
- Hypotension causing weakness and fainting
- Disorientation
- Hallucinations
- Unstable gait
- Tremor
- Muscle twitching, seizures
- Myasthenia gravis
- Kidney failure

Methadone Withdrawal

Methadone is a (synthetic opiate) narcotic that when administered once a day, orally, in adequate doses, can usually suppress a heroin addict's craving and withdrawal for 24 hours. Patients are as physically dependent on methadone as they were to heroin or other opiates, such as oxycotin or vicodin. Ironically, methadone used to control narcotic addiction is frequently encountered on the illicit market and has been addicted with a number of overdoes deaths. Tolerance and addiction to methadone is a dangerous threat, as methadone withdrawal results from the cessation of use. Many former heroin users have claimed that the horrors of heroin addiction withdrawal were far less painful than methadone withdrawal.

Many people go from being addicted to heroin to being addicted to methadone, and continue with the "treatment" for years, fearing the withdrawal that will occur when they stop. Methadone does not have to be the way of life for former heroin addicts. Gradual cessation followed by a drug-free program of rehabilitation may be the answer for many sufferers.

- Sneezing, runny nose, yawning
- Tearing of eyes, excessive perspiration
- Fever, abdominal cramps, body aches
- Dilated pupils
- Nausea, tremors

After several days of stabilizing a patient with methadone, the amount can be gradually decreased. The rate at which it is decreased is dependent on the reaction of the individual…keeping methadone withdrawal symptoms at a tolerable level is the goal.

Morphine Side Effects

Morphine is narcotic analgesic. Morphine was first isolated from opium in 1805 by German pharmacist, Wilhelm Serturner.
Serturner described it as the Principium Somniferum. He named it morphine, after Morpheus, the Greek god of dreams.. Today , morphine is isolated from opium in substantially larger quantities—over 1000 tons per year—although most commercial opium is converted into codeine by methylation. On the illicit market, opium gum is filtered into morphine base and then synthesized into heroin.

Morphine side effects include, but are not limited to:

- Abdominal pain
- Abnormal thinking, anxiety, agitation, apprehension,
- Allergic reaction
- Accidental injury
- Appetite loss, dry mouth
- Blurred/double vision, "pinpoint" vision
- Chills, sweating
- Constipation, cramps, diarrhea
- Depressed/irritable mood
- Dizziness, drowsiness
- Exaggerated sense of well-being, hallucinations
- Facial flushing, fainting, floating feeling
- Itching, rash, hives, tingling or pins and needles
- Headache, memory loss, light-headedness
- Inability to urinate
- Insomnia

Morphine Withdrawal

Morphine addiction develops very rapidly when an individual continues to abuse the drug. Morphine's addictive nature activates the brain's reward system. The promise of reward is very intense, causing the individual to continually crave and focus his or her activities around taking Morphine. The ability of Morphine to strongly activate the brain's reward mechanisms and it's ability to chemically alter the normal functioning of these systems is what produces morphine addiction. Morphine also reduces a person's level of consciousness, harming the ability to think or be fully aware of present surroundings.

Morphine withdrawal symptoms include, but are not limited to:

- Abdominal and muscle cramps
- Diarrhea
- Hot and cold flashes
- Increases in body temperature, blood pressure, respiratory rate and heart rate
- Inflammation of the nasal mucus membrane
- Insomnia
- Nausea or vomiting
- Perspiration, goose flesh
- Prolonged, abnormal dilation of pupils
- Restlessness
- Runny nose
- Severe aches in the back, abdomen, and legs
- Severe sneezing
- Twitching and spasms of muscles, kicking movements
- Watery eyes
- Yawning

Morphine withdrawal symptoms reach peak intensity in 36-72 hours. Without treatment, withdrawal symptoms run their course in 5-7 days, even though cravings for Opium may continue for months.

Opium Side Effects

Opium is the crudest form and also the least potent of the Opiates. Opium is the milky latex fluid contained in the un-ripened seed pod of the opium poppy. As the fluid is exposed to air, it hardens and turns black in color. This dried for is typically smoked, but can also be eaten. Opium is grown mainly in Myanmar (former Burma) and Afghanistan. Opium is highly addictive. Tolerance and physical and psychological dependence develop quickly.

Being of similar structure, the opiate molecules occupy many of the same nerve receptor sites, and bring on the same analgesic effect as the body's natural painkillers. Opiates first produce a feeling of pleasure and euphoria, but with their continued use, the body demands lager amounts to reach the same sense of well-being.

Opium side effects include, but are not limited to:

- Malnutrition
- Respiratory complications
- Low blood sugar

Opium Withdrawal

When first used, opium can give users a feeling of euphoria, extreme calm, or well-being. Their troubles may seem unimportant and nothing else really matters, except for the fact that the drug works. But often, nightmares and hallucinations may come into play when the affects of the drug wear off. At that point, individuals with an opium addiction will often need more of the opium to satisfy their need for more. As time goes on, the addict develops an increasing tolerance to the effects of the drug, and more and more of the drug is needed to produce the initial affect of euphoria. Many individuals who suffer from an addiction to opium will eventually get symptoms of withdrawal after years of using Opium.

Opium Withdrawal symptoms include, but are not limited to:

- Nausea or vomiting
- Sweating
- Cramps, diarrhea
- Loss of appetite
- Muscle spasms
- Depression
- Anxiety, mood swings
- Insomnia

OxyContin Side Effects

OxyContin, approved by the FDA in 1995, an opium derivative, which is the same active ingredient in Percodan and Percocet. OxyContin is intended for use by terminal cancer patients and chronic pain sufferers. It has been linked to at least 120 overdose deaths nationwide.

Respiratory depression is the chief hazard from all opioid usage. Respiratory depression occurs most frequently in elderly or debilitated patients, usually following large initial doses in non-tolerant patients, or debilitated patients, or when opioids are given in conjunction with other agents that depress respiration.

Opioid side effects include, but are not limited to:

- Constipation, nausea, vomiting
- Dizziness, headache, sedation
- Dry mouth, sweating, weakness

Oxycontin should be used with extreme caution in patients with significant chronic obstructive pulmonary disease and in patients having a substantially decreased respiratory reserve, hypoxia, hypercapnia, or preexisting respiratory depression. In such patients, even usual therapeutic doses of OxyContin may decrease respiratory drive to the extent of apnea. In these patients, alternative non-opioid analgesics should be considered, and opioids should be employed only under careful medical supervision, at the lowest effective dose. OxyContin causes miosis, even in total darkness. Pinpoint pupils are a sign of opioid overdose but are not path gnomonic. Marked mydriasis rather than miosis may be seen due to hypoxia in overdose situation.

→ **Gastrointestinal tract and other smooth muscle**
OxyContin causes a reduction in motility associated with an increase in smooth muscle tone in the antrum of the stomach and duodenum. Digestion of food in the small intestine is delayed and propulsive contractions are decreased. Propulsive peristaltic waves in the colon are decreased, while tone may be increased to the point of spasm resulting in constipation. Other opioid-induced effects:

- Reduction in gastric, biliary and pancreatic secretions
- Spasm of sphincter of Oddi
- Transient elevations in serum amylase

→ **Cardiovascular system**
OxyContin may produce release of histamine with or without associated peripheral vasodilatation. Manifestations of histamine release and/or peripheral vasodilatation may include:

- Prurits
- Flushing
- Red eyes
- Sweating
- Orthostatic hypotension

Concentration – Efficacy relationships (Pharmacodynamics)

Studies in normal volunteers and patients reveal predictable relationships between OxyContin dosage and plasma OxyContin concentrations, as well between concentration and certain expected opioid effects. In normal volunteers these effects include:

- Papillary constriction
- Sedation
- Overall "drug effect"

In patients, these effects include:

- Analgesia
- Feelings of "relaxation"

In non-tolerant patients, analgesia is not usually at a plasma OxyContin concentration of less the 5 to 10 ng/mL.

As with all opioids, the minimum effective plasma concentration for analgesia will vary widely among patients, especially among patients who have been previously treated with potent opioids. As a result, patients need to be treated with individualized titration of dosage to the desired effect. The minimum effective analgesic concentration of OxyContin for any individual patient may increase with repeated dosing due to an increase in pain and/or the development of tolerance.

OxyContin Withdrawal

The powerful prescription pain reliever, OxyContin, has become a hot new street drug that has resulted in more than 120 deaths nationwide. It will give you a high much like HIGH GRADE heroin, but with worse consequences. 5mg of OxyContin has as much active ingredient (OxyCodone) as one Percocet. So, chewing/snorting a 40mg Oxycontin is like taking 8 Percocets at once or a 80mg OxyContin is like taking 16 Percocet's all at once.

OxyContin, approved by the FDA in 1995, an opium derivative, which is the same active ingredient in Percodan and Percocet. OxyContin is intended for use by terminal cancer patients and chronic pain sufferers. OxyContin addiction is a physical dependence that in unavoidable when an individual is exposed to high doses of the drug for an extended period of time. The body then adapts and develops a tolerance for OxyContin. The addiction is so powerful that it produces cravings. These cravings for OxyContin are the result of its impact on the individual's memory with feelings of pleasantness and euphoria which the individual has come to associate with the taking of OxyContin. The subconscious memory then motivates the individual to seek this drug because of its false imprint of OxyContin.

OxyContin withdrawal symptoms include, but are not limited to:

- Perpetually being tired
- Hot/cold sweats
- Heart palpitations
- Joints and muscles in constant pain
- Nausea and vomiting
- Uncontrollable coughing
- Diarrhea
- Insomnia
- Watery eyes
- Excessive yawning
- Depression

Percocet Side Effects

Percocet is a narcotic (OxyCodone) and acetaminophen combination. They are combined to get a synergistic effect on pain. Oxycodone is similar to other narcotics in terms of effect and addiction. Acetaminophen is better known as Tylenol.

Percocet side effects include, but are not limited to:

- Drowsiness
- Constricted pupils
- Nausea or vomiting
- Euphoria, exaggerated sense of well-being
- Dizziness, light-headedness
- Sedation
- Constipation
- Depressed feeling
- Itchy skin, skin rash
- Slowed breathing

Percocet Withdrawal

Percocet addiction can affect the young, middle-aged, or elderly. Individuals addicted to Percocet may come from any walk of life, hold entry level or high positions, be parents or grandparents, single or married. Often, the addiction to Percocet develops without the individual realizing it until it begins to control their life. When an individual exceeds the dosage prescribed or seeks to obtain Percocet after the time prescribed by their physician, they should be aware of the possibility that they have developed a Percocet addiction. Abruptly stopping or reducing the intake of Percocet can cause severe withdrawal symptoms. These begin 6-8 hours after the last dose.

Percocet withdrawal symptoms include, but are not limited to:

- Feeling as though you have the flu
- Gastrointestinal distress
- Anxiety
- Insomnia
- Muscle pain
- Fevers, sweating
- Runny nose and eyes

Ultram Side Effects

Ultram is the brand name of the generic drug Tramadol. Ultram is an analgesic used to treat or prevent pain. Ultram is not a non-steroidal anti-inflammatory drug, nor is it a narcotic. Ultram binds to certain opioid pain receptors in the body. By blocking the reuptake of the neurochemical norephinephrine and serotonin, it modifies the pain message resulting in pain relief.

Ultram side effects include, but are not limited to:

- Dizziness, drowsiness
- Nausea, dry mouth
- Constipation
- Headache
- Difficulty breathing or tightness of chest
- Swelling of eyelids, face, or lips
- Sweating, rash, hives

Ultram Withdrawal

Introduced in 1995, no control was recommended based on review of its uncontrolled use in 40 other countries. However, once released in the U.S., abuse became readily apparent. It is addictive. It is a "non-narcotic" pain reliever. Large doses can interfere with ability to breathe, especially if taken with alcohol.

- Difficulty sleeping
- Agitation, irritability
- Hallucinations, dizziness
- Depression
- Diarrhea
- Lethargy
- Body aches, sweats
- Increase in tremor

Vicodin Side Effects

Vicodin is one of the most commonly abused prescription pain medications today. One of the most widely prescribed medications, Vicodin and its related medications (Loricet, Loritab, Percodan, OxyContin), are opioid-based pain medications. Vicodin is a derivative of opium, which is also used to manufacture heroin. Individuals with a Vicodin addictions become deeply depressed, and their thinking, attention, and judgment become impaired. Their thoughts dwell on the next high, although they tell themselves they are still taking Vicodin for pain or to avoid the withdrawal symptoms. Individuals with a Vicodin addiction often truly feel physical pain, but it is psychologically produced.

Individuals with a Vicodin addiction crave more Vicodin and tolerate greater amounts of the drug to achieve their high. Vicodin addicts to great lengths, even breaking the law to get Vicodin. They continue abusing even though they suffer negative physical and social consequences. Vicodin addicts are often aware of their addiction, but may be too embarrassed or stubborn to admit it.

Vicodin Withdrawal

If a regular Vicodin user stop taking Vicodin, he of she will experience Vicodin withdrawal within 6-12 hours, but the symptoms are usually not life-threatening. The intensity of Vicodin withdrawal depends on the degree of the addiction. For example, the symptoms of withdrawal from Vicodin may grow stronger for 24-72 hours and then gradually decline over a period of 7-14 days.

The symptoms of Vicodin withdrawal include, but are not limited to:

- Restlessness, insomnia
- Muscle pain, bone pain
- Diarrhea
- Nausea or vomiting
- Cold flashes, goose bumps, chills
- Involuntary leg movements
- Watery eyes
- Loss of appetite
- Irritability, panic
- Sweating

Xanax Side Effects

Xanax is prescription tranquilizer which depresses the nervous system in a way similar to alcohol. Xanax has found its way from pharmacies to drug dealers, and is being abused by young, healthy people who want to get high. These club-hopping, 20-something, casual "Xannie poppers" are using the drug in combination with other stimulants, from alcohol to cocaine.

Xanax Withdrawal

Essentially, withdrawal symptoms from Xanax feel like the opposite of the therapeutic effects. Xanax withdrawal symptoms are similar to those in alcohol withdrawal.

The symptoms of Xanax withdrawal include, but are not limited to:

- Jitteriness, shaky feelings
- Rapid heartbeat
- Insomnia, disturbed sleep
- Irritability, anxiety, agitation

Confuse-Ant® drugs confuse or distort thinking, feeling and behavior.

COMMON ABUSED DRUGS	COMMON STREET NAMES
Ecstasy	E-bombs, Ex, Tabs, Yips
Gammahydroxybutyrate	GHB, Georgia Home Boy, Swirl, Scoop
Inhalants	Air Blast, Bang, Whippets, poppers, snappers
LSD	Acid, DSL, Paper, Rips, Tabs, Trip, Window Pane
Marijuana	4.20, Broccoli, Cheeba, Funk, MJ, Stuff, Time
Mescaline	Dusty, Mesc, Peyote, Pixie Sticks
Phencyclidine	Angel Dust, Ice, Leak, PCP, Sherm, Wet

Marijuana Side Effects

Marijuana is a green or gray mixture of dried, shredded flowers and leaves of the hemp plant (Cannabis sative). It is the most often used illegal drug in this country. All forms of cannabis are mind-altering (psychoactive) drugs; they all contain THC (delta-9-tetrahydrocannabinol), the main active chemical in marijuana. There are about 400 chemical in a cannabis plant, but THC is the one that affects the brain the most.

Marijuana's effect on the user depends on the strength or potency of the THC it contains. THC potency has increased since the 1970s, but has been about the same since the mid-1980s. The strength of the drug is measured by the average amount of THC in test samples confiscated by law enforcement agencies.

What are the side effects of Marijuana?

Enhanced cancer risk
Decrease in testosterone levels and lower sperm counts for men
Increase in testosterone levels for women and increased risk of infertility
Diminished or extinguished sexual pleasure
Psychological dependence requiring more of the drug to get the same effect

What are the effects of Marijuana on Men?

Marijuana is the most common drug used by adolescents in America today. Marijuana affect the parts of the brain which controls the sex and growth hormones. In males, marijuana can decrease the testosterone level. Occasional cases of enlarged breasts in male marijuana users are triggered by the chemical impact on the hormone system. Regular marijuana use can also lead to a decrease in sperm count, as well as, increases in abnormal and immature sperm. Marijuana is a contributing factor in the rising problem of infertility in males. Young males should know the effects and potential effects of marijuana use on sex and the growing process before they decide to smoke marijuana.

What are the effects of Marijuana on Women?

Just as in males, marijuana affects the female in the part of the brain that controls the hormones, which determines the sequence in the menstrual cycle. It's been said that females who smoked or used marijuana on a regular basis, had irregular menstrual cycles, the female hormones were depressed, and the testosterone level was raised. Even though this effect may be reversible, it may take several months of no marijuana use before the menstrual cycles become normal again. Mothers who smoke marijuana on a regular basis have been reported of having babies with a weak central nervous system. These babies show abnormal reactions to light and sound, exhibit tremors and startles, and have the high-pitched cry associated with drug withdrawal. Occurring at five times the rate of Fetal Alcohol Syndrome, Fetal Marijuana Syndrome is a growing concern of many doctors.

Furthermore, doctors worry that children born to "pot-head" mothers will have learning disabilities, attention deficits and hormonal irregularities as they grow older, even if there are no apparent signs of damage at birth. Pregnant or nursing mothers who smoke marijuana should to talk to their doctors immediately.

What are the effects of Marijuana on the lungs?

Regular users may have many of the same respiratory problems experienced by tobacco smokers. Individuals may have daily cough and phlegm, symptoms of chronic bronchitis, and more frequent chest colds. Continual usage can lead to abnormal functioning of lung tissue injured or destroyed by marijuana smoke. Regardless of the THC content, the amount of tar inhaled by marijuana smokers and the level of carbon monoxide absorbed are 3-5 times greater than among tobacco smokers. This may be due to marijuana users inhaling more deeply and holding smoke in the lungs.

What are the effects of Marijuana on heart rate and blood pressure?

Recent findings indicate that smoking marijuana while shooting up cocaine has the potential to cause severe increases in heart rate and blood pressure. In one study, experienced marijuana and cocaine users were given marijuana alone, cocaine alone, and then a combination of both. Each drug alone produced cardiovascular effects. When combined, the effects were greater and lasted longer. The subject's heart rates increased 29 beats per minute with marijuana alone, and 32 beats per minute with cocaine alone. Given together, the heart rate increased by 49 beats per minute, and increase persisted for a longer time. The drugs were given with the subjects sitting quietly. In normal circumstances, an individual may smoke marijuana and inject cocaine and increase the risk of overload on the cardiovascular system.

What are the effects of heavy Marijuana use on learning and social behavior?

A study of college students has shown that critical skills related to attention, memory, and learning are impaired among people who use marijuana heavily, even after discontinuing its use for at least 24 hours. Researchers compared 65 "heavy users," who smoked marijuana a median of 29 of the past 30 days, and 64 "light users" who smoked a median of 1 of the past 30 days. After a closely monitored 19 to 24 hour period of abstinence from marijuana and other illicit drugs and alcohol, the undergraduates were given several standard tests measuring aspects of attention, memory, and learning. Compared to the light users, heavy smokers made more errors and had more difficulty sustaining attention, shifting attention to meet the demands of changes in the environment, and in registering, processing, and using information. The findings suggest that the greater impairment among heavy users is likely due to an alteration of brain activity produced by marijuana.

Longitudinal research on marijuana use among young people below college age indicates those who used have lower achievement than the non-users, more acceptance of deviant behavior, more delinquent behavior and aggression, greater rebelliousness, poorer relationships with parents, and more associations with delinquent drug-using friends.

What are the effects of Marijuana on pregnant women?

Studies have found that babies born to mothers who used marijuana during pregnancy were smaller than those born to mothers who did not use the drug. In general, smaller babies are more likely to develop health problems.
A nursing mother who uses marijuana passes some of the THC to the baby in her breast milk. Research indicates that the use of marijuana by a mother during the first month of breast feeding can impair the infant's motor development (control of muscle movement). Research also shows more anger and more regressive behavior (thumb sucking, temper tantrums) in toddlers whose parents use marijuana than among the toddlers of non-using parents.

Marijuana Withdrawal

Marijuana addiction is a phenomenon experienced by more than 150,000 individuals each year who enter treatment for their proclaimed addiction to marijuana. Marijuana addiction is characterized as compulsive, often uncontrollable marijuana craving, seeking and use, even when the individual knows that marijuana use is not in his best interest. Marijuana addiction could be defined as chronically making the firm decision not to use marijuana followed shortly by a relapse due to experiencing overwhelming compulsive urges to use marijuana despite the firm decision not to. This contradiction is characteristic of an addiction problem.

Marijuana withdrawal symptoms include, but are not limited to:

- Irritability
- Anxiety
- Physical tension
- Decreases in appetite and mood

Symptoms of marijuana withdrawal first appear in chronic users within 24 hours. Marijuana withdrawal is most pronounced for the first 10 days and can last up to 28 days.

Ecstasy Side Effects

MDMA, or ecstasy, is a Schedule I synthetic, psychoactive drug possessing stimulant and hallucinogenic properties. Ecstasy possesses chemical variations of the stimulant amphetamine or methamphetamine, and most often mescaline which is a hallucinogen. Commonly referred to as Ecstasy or XTC, MDMA was first synthesized in 1912 by a German company possibly to be used as an appetite suppressant. Chemically, it is an analogue of MDA, a drug that was popular in the 1960s. Today, Ecstasy is most often distributed at late-night parties called "raves," nightclubs, and rock concerts. As the rave and club scene expands to metropolitan and suburban areas across the country, ecstasy use and distribution are increasing as well.

The designer drug "Ecstasy," or MDMA, causes long-lasting damage to brain areas that are critical for thought and memory, according to new research findings in the June 15 issue of The Journal of Neuroscience. In an experiment with red squirrel monkeys, researchers at The Johns Hopkins University demonstrated that 4 days of exposure to the drug caused damage that persisted 6 to 7 years later. These findings help to validate previous research by the Hopkins team in humans, showing that people who had taken ecstasy scored lower on memory tests.

"The serotonin system, which is compromised by ecstasy, is fundamental to the brain's integration of information and emotion," says Dr. Alan I Heshner, Director of the National Institute on Drug Abuse (NIDA), National Institutes of Health, which funded the research. "At the very least, people who take ecstasy, even just a few times, are risking long-term, perhaps permanent, problems with learning and memory.

Researchers found that the nerve cells (neurons) damaged by ecstasy are those that use the chemical serotonin to communicate with other neurons. The Hopkins team had also previously conducted brain imaging research in human ecstasy users, in collaboration with the National Institute of Mental Health, which showed extensive damage to serotonin neurons.

MDMA (3, 4-methylenedioxymethamphetamine) has a stimulant effect, causing similar euphoria and increased alertness as cocaine and amphetamine. It also causes mescaline-like psychedelic effects. First used in the 1980s, MDMA is often taken at large, all-night "rave" parties.

In this new study, the Hopkins researchers administered either MDMA or salt water to the monkeys twice a day, for 4 days. After 2 weeks, the scientists examined the brains of half of the monkeys. Then, after 6-7 years, the brains of the remaining monkeys were examined, along with age-matched controls.

In the brains of the monkeys examined soon after the 2-week period, Dr. George Ricaurte and his colleagues found that MDMA caused more damage to serotonin neurons in some parts of the brain than in others. Areas particularly affected were the noecortex (the outer part of the brain where conscious thought occurs), and the hippocampus (which plays a key role in forming long-term memories.

This damage was also apparent, although to a lesser extent, in the brains of monkeys who had received MDMA during the same 2-week period but who had received no MDMA for 6-7 years. In contrast, no damage was noticeable in the brains of those who had received salt water. "Some recovery of serotonin neurons was apparent in the brains of the monkeys given MDMA 6 to 7 years previously," says Dr. Ricaurte, "but this recovery occurred only in certain regions, and was not always complete. Other brain regions showed no evidence of recovery whatsoever."

A NIDA-supported study has provided the first direct evidence that chronic use of MDMA, popularly known as "ecstasy," causes brain damage in people. Using advanced brain imaging techniques, the study found that MDMA harms neurons that release serotonin, a brain chemical thought to play an important role in regulating memory and other functions. In a related study, researchers found that heavy MDMA users have memory problems that persist for at least 2 weeks after they have stopped using the drug. Both studies suggest that the extent of damage is directly correlated with the amount of MDMA use.

"The message from these studies is that MDMA does change the brain and it looks like there are functional consequences to these changes," says Dr. Joseph Frascella of NIDA's Division of Treatment Research and Development. That message is particularly significant for young people who participate in large, all-night dance parties known as "raves," which are popular in many cities around the nation. NIDA's epidemiologic studies indicate that MDMA 93, 4-methyleneioxymethamphetamine) use has escalated in recent years among college students and young adults who attend these social gatherings.

Ecstasy Withdrawal

Ecstasy users may encounter problems similar to those experienced by amphetamine and cocaine users, including Ecstasy addiction.

Ecstasy is psychologically addicting and the most common withdrawal symptoms include:

- Depression
- Anxiety
- Panic attacks
- Sleeplessness
- “de-personalization”
- “de-realization”
- Paranoid delusions
- Rush
- Depressed respiration
- Clouded mental functioning
- Nausea and vomiting
- Suppression of pain
- Spontaneous abortion

Stim-U-Ant® (stimulant) drugs stimulate or increase thinking, feeling and behavior.

Common Abused Drugs	Common Street Names
Cocaine	7 up, Angie, Cane, Flake, Kitty, Rails, White Pony
Crack	Base, Cloud, Devil's smoke, Gravel, Paste, Soup
Dexedrine	Dexies, Little Guys, Sprinkles, Tweek
Heroin	Blast, Cheese, Gold, Horse, Slam, Tar, White Tiger
Methamphetamine	Amp, G, Meth, Pure, Twack, Zip
Ritalin	Kibbles and bits, Pinapple

COCAINE SIDE EFFECTS

Cocaine is derived from the leaves of the cocoa bush grown in South America. Widespread use and addiction led to government efforts against cocaine in the early 1900s. The danger associated with cocaine was ignored in the 1970s and early 1980s, and cocaine was proclaimed by many to be safe. With the accumulating medical evidence of cocaine's destructive effects, and the introduction and widespread use of cocaine, the public and government have become alarmed again about its growing use. To many Americans, especially health care and social workers who deal with and witness the personal and societal devastating effects on cocaine users, cocaine addiction is, by far, the most serious drug problem in the United States.

Cocaine side effects include, but are not limited to:

- Changes in blood pressure, heart rates, breathing rates
- Nausea or vomiting
- Anxiety, restlessness, insomnia
- Convulsions
- Loss of appetite leading to malnutrition and weight loss
- Cold sweats
- Swelling and bleeding of mucous membranes
- Damage to nasal cavities; damage to lungs
- Possible heart attacks, strokes, or convulsions

Even though the public is often entertained with highly publicized accounts of deaths from cocaine, many still mistakenly believe the drug (especially when sniffed) to be non-addictive and not as harmful as other illicit drugs. Cocaine's immediate physical effects include raised breathing rare, raised blood pressure and body temperature, and dilated pupils. By causing the coronary arteries to constrict, blood pressure rises and the blood supply to the heart diminishes. This can cause heart attacks or convulsions within an hour after use. Chronic users and those with hypertension, epilepsy, and cardiovascular disease, are at particular risk. Studies show that even those with no previous heart problems risk cardiac complications from cocaine. Increased use may sensitize the brain to the drug's effects so that less of the substance is needed to induce a seizure. Those who inject the drug are at high risk for AIDS and hepatitis when they share needles. Allergic reactions to cocaine or other substances mixed in with the drug may also occur.

Cocaine Withdrawal

Cocaine addiction can occur very quickly and be very difficult to break. Studies have shown that animals will work very hard (press a bar over 10,000 times) for a single injection of cocaine, choose cocaine over food and water, and take cocaine even when this behavior is punished. Animals must have their access to cocaine limited in order not to take toxic or even lethal doses. People addicted to cocaine behave similarly. They will go to great lengths to get cocaine and continue to take it even when it hurts their school or job performance and their relationships with loved ones.

Regular use of cocaine can lead to strong psychological dependence (addiction). Those who abruptly stop their cocaine use can experience cocaine withdrawal symptoms as they readjust to functioning without the drug. The length of cocaine withdrawal varies person to person and on the amount and frequency of use.

Cocaine withdrawal symptoms include, but are not limited to:

- Agitation, anxiety, angry outbursts, irritability
- Depression, lack of motivation, extreme fatigue
- Intense craving for the drug
- Nausea/vomiting
- Shaking
- Muscle pain
- Disturbed sleep

Crack Side Effects

The chemical cocaine hydrochloride is commonly known as crack. Some users chemically process cocaine in order to remove the hydrochloride. This process is called "freebasing," and makes the drug more potent. "Crack" is a solid form of freebased cocaine. Crack addiction is one of society's greatest problems today. Individuals addicted to crack will do almost anything to get the drug. It has penetrated all levels of our society (rich, poor, and everyone in between). Family members connected to crack addicts live in chaos and confusion. Not understanding the underlying mechanics of cocaine addiction.

Crack side effects include, but are not limited to:

- Nausea or vomiting
- Anxiety, restlessness
- Convulsions
- Insomnia
- Loss of appetite leading to malnutrition, weight loss
- Cold sweats
- Swelling and bleeding of mucous membranes
- Damage to nasal cavities
- Damage to lungs
- Possible heart attacks, strokes, or convulsions

Crack is inhaled and rapidly absorbed through the lungs, into the blood, and carried swiftly to the brain. The chances of overdosing and poisoning leading to coma, convulsions, and death are greatly increased. Crack's rapid rush (5-7 minutes of intense pleasure) quickly subsides, leading to depression that needs to be relieved by more crack. This cycle enhances the chances of addiction and dependency. Because of the brief high, users are constantly thinking about and devising ways to get more. Psychologically, the drug reduces concentration, ambition, and drive, and increases confusion and irritability, wreaking havoc on users' professional and personal lives. Habitual use may lead to cocaine psychosis, causing paranoia, hallucinations, and a condition known as formication, in which insects or snakes are perceived to be crawling under the skin. The paranoia and depression can instigate violent and suicidal behavior. The side effects of adulterants increase cocaine's risks. The drug is often cut with one or more of any number of other substances, such as the cheaper drugs procaine, lidocaine, and benzocaine, and substances that pose no serious risks, such as sugars (mannitol and sucrose), or starches. However, when quinine or amphetamines are added, the potential for serious side effects increases dramatically.

Crack Withdrawal

According to the 2001 National Household Survey on Drug Abuse, approximately 6.2 million (2.8%) Americans age 12 or older had tried crack at least once in their lifetime, 1 million (0.5%) used crack in the past year, and 406,000 (0.2%) reported use in the past month. Users who become addicted will "crave" more of the drug as soon as the intoxicating effects wear off, if they do not get their regular dose.

Crack is an extremely powerful drug. Crack addiction is inevitable; once the individual has tried crack, they may be unable to predict or control the extent to which they will continue to use. Crack is probably the most addictive substance yet devised. Users need more and more to attain the same high and avoid the intense "crash" or depression that follows their high. Addicted individuals become physically and psychologically dependent on crack, which often is a result of only a few doses taken within a few days. This dependence leads to crack addiction. To balance the intense lows, crack addicts often use other drugs, such as, alcohol, hash or marijuana in addition to crack.

Crack withdrawal symptoms include, but are not limited to:

- Agitation, Angry outbursts, Anxiety
- Depression, Disturbed sleep
- Extreme fatigue
- Intense craving for drug, Irritability
- Lack of motivation
- Muscle Pain
- Nausea/vomiting

Dexedrine Side Effects

Dextroamphetamine (Dexedrine) is an amphetamine, belonging to the group of medicines called central nervous system (CNS) stimulants. It is a Schedule II controlled substance. Dexedrine was often used in the late 1960s and early 1970s as a prescription diet aid because one of the effects of such a stimulant drug is to suppress appetite. Dexedrine (and its more potent cousin, Benezedrine) was also commonly (and illegally) used by college students either for the stimulant high or as a study aid.

Dexedrine side effects include, but are not limited to:

- Addiction
- Agitation/irritability
- Behavior disturbances
- Diarrhea, constipation
- Dizziness
- Dry mouth
- Elevation of blood pressure
- Euphoria
- Exacerbation of motor skills
- Hallucinations
- Headache
- Increased heart rate
- Insomnia
- Liver irritation/toxicity
- Nausea
- Over stimulation
- Restlessness
- Sexual difficulties
- Tics
- Tourette's syndrome
- Weight loss

Dexedrine Withdrawal

Dexedrine is highly addictive. Individuals form an addiction to Dexedrine due to its ability to sustain energy and lose weight. Dexedrine addiction may lead to serious complications such as heart rate and blood pressure Withdrawal symptoms from Dexedrine are characterized by depression and extreme fatigue. Fortunately, the withdrawal symptoms tend to be mostly psychological and not medical.

Dexedrine withdrawal symptoms include, but are not limited to:

- Depression
- Fatigue
- Irritability
- Long but disturbed sleep
- Strong hangover
- Violence

Heroin Side Effects

Heroin is an illegal, highly addictive opiate drug. Abuse is more widespread than any other opiate. Heroin is processed from morphine, a naturally occurring substance extracted from the seed pod of certain varieties of poppy plants. It is typically sold as a white or brownish powder, or as the black sticky substance known on the streets as "black tar heroin." One of the most detrimental side effects of heroin is, heroin addiction itself. Heroin addiction is a chronic problem, characterized by compulsive drug seeking and use, and by neurochemical and molecular changes in the brain. Heroin also produces profound degrees of tolerance and physical addiction, which are also powerful motivating factors for compulsive use and abuse. As with abusers of any addictive drug, heroin addicts gradually spend more and more time and energy obtaining and using the drug. Once they are addicted, the heroin abusers' primary purpose in life becomes seeking and using heroin. Heroin literally changes their brains.

Short term heroin side effects include, but are not limited to:

- Rush, Depressed respirations
- Clouded mental functioning
- Nausea and vomiting
- Suppression of pain

Long term heroin side effects include, but are not limited to:

- Addiction, Abscesses
- Collapsed veins, Bacterial infections
- Infection of heart lining and valves
- Arthritis and other rheumatologic problems
- Infectious diseases, for example, HIV/AIDS and hepatitis B and C

Heroin Withdrawal

Heroin withdrawal symptoms are some of the nastiest an addict can experience compared to withdrawal from any other drug. The individual who has become physically, as well as psychologically dependent on heroin, will experience heroin withdrawal with an abrupt discontinuation of use or even a decrease in their daily amount of heroin taken. The onset of heroin withdrawal symptoms begin 6-8 hours after the last dose is administered. Major heroin withdrawal symptoms peak between 48-72 hours after the last dose of heroin and subdue after about one week. The symptoms of heroin withdrawal produced are similar to a bad case of the flu.

Symptoms of heroin withdrawal include, but are not limited to:

- Dilated pupils, watery eyes
- Piloerection (goose bumps)
- Runny nose
- Yawning
- Loss of appetite
- Tremors, shaking, jitteriness
- Panic, irritability
- Nausea or vomiting
- Muscle cramps
- Insomnia
- Stomach cramps
- Diarrhea
- Chills or profuse sweating

Ritalin Side Effects

Ritalin (methylphenidate) is a central nervous system stimulant similar to amphetamines in nature and duration of it's effects. It is believed that it works by activating the brain stem arousal system an cortex. Pharmacologically, it works on the neurotransmitter dopamine, and in that respect resembles the stimulant characteristics of cocaine. When taken in accordance with usual prescription instructions, it would be classified as having mile to moderate stimulant properties, but when snorted or injected, it has a strong stimulant effect.

Ritalin side effects include, but are not limited to:

- Nervousness, paranoia, hallucinations, delusions, anxiety, restlessness
- Insomnia
- Loss of appetite
- Nausea or vomiting
- Dizziness, headache
- Changes in heart rate and blood pressure
- Skin rashes, itching, fevers
- Abdominal pain
- Weight loss, digestive problems, loss of appetite (malnutrition)
- Toxic psychosis
- Psychotic episodes
- Severe depression upon withdrawal, death
- Tremors, muscle twitch, convulsions

Ritalin Withdrawal

Ritalin is an addictive drug and mimics the action of chemicals your brain produces to send messages of pleasure to your brain's reward center. Ritalin produces an artificial feeling of pleasure to your brain's reward center. Ritalin produces an artificial feeling of pleasure. Ritalin produces its pleasurable effects by chemically acting like certain normal brain messenger chemicals, which produce positive feelings in response to signals from the brain. The result in an addiction to Ritalin because the individual can depend on the immediate, fast, predictable high Ritalin provides. At the same time, Ritalin short circuits interests in and the motivation to make life's normal rewards work. More and more confidence is placed on Ritalin while other survival feelings are ignored and bypassed. Ritalin withdrawal varies in severity and length. The withdrawal from Ritalin addiction depends on the amount and duration of time an individual was addicted.

Ritalin withdrawal symptoms include, but are not limited to:

- Agitation, anxiety
- Insomnia, nausea
- Severe emotional depression
- mnia, exhaustion

DETOXIFICATION

1.15.01 The Regional Alcohol and Drug Detoxification Program will not admit any client under 18 years of age.

1.15.02 Observation detoxification, with or without medical supervision, will include:

a. Gender separate sleeping areas with:

1. One-level bed (no bunk beds) per client;

2. Individual storage for clothing items;

3. Window coverings to allow for privacy;

4. Sufficient clean linen supply with covered storage.

a. Storage will be at least 12 inches above the floor; and

b. Non-permeable container(s) to hold used linen.

b. Gender separate bathroom/shower areas with:

Sufficient lighting so as to avoid injury;

Plumbing in working condition so as to avoid any threat to health;

3. Sufficient clean linen supply with covered storage; and

a. That storage will be least 12 inches above the floor; and

b. Non-permeable container(s) to hold used linen.

c. Three meals a day, with no more than 14 hours between any two meals:

1. There will be documentation of meals offered, consumed and/or refused;

2. There will be documentation of reason for not offering nutrition. (e.g. client absent during meal time to see personal physician); and
3. There will be no preparation of meals by detoxification client(s).

d. Easily accessible oral fluids for clients; there will be documentation of amount offered, and amount consumed or refused, every two (2) hours.

e. Clients in detoxification services will have their vital signs taken upon admission and documented; and at least every two (2) hours thereafter, until within normal limits for 8 hours.

Exception: Blood pressure, temperature and pulse may be omitted one (1) time per twenty-four (24) hour period; observation will continue as evidenced by documentation of reason for vital sign omission, client behavior observed and respiration count. (e.g. Vital signs completed at 10:00 p.m., description of behavior client exhibiting at midnight and resume vital signs at 2:00 a.m.);

Once vital signs are within normal limits for eight (8) hours, they will be taken no less than every six (6) hours. There will be documentation in the client's case record verifying each vital sign taken during the client's stay in detoxification; and

A complete set of vital signs will include blood pressure reading (systolic and diastolic), temperature, pulse and respirations.

1.15.03 While a client is in an observation detoxification component (with or without medical supervision), qualified staff member(s) (registered and/or licensed practical nurse or Regional Detoxification Specialists) must be present and specifically assigned to monitor the client on a twenty-four (24) hour basis.

1.15.04 There will be documentation in personnel files, about which staff members assigned to any detoxification unit are knowledgeable about the taking of vital signs and the implication of those vital signs. There is documentation of the following and current certification, as appropriate:

Cardiopulmonary Resuscitation (CPR);

First Aid;

Non-violent Crisis Intervention (CPI);

Signs and symptoms of withdrawal, and the implication of those signs and symptoms; and

Emergency procedures, as defined in facility policy and procedure manual:

The program will have written policy and procedures for emergencies;

Emergency policy and procedures will be readily available to all staff;

Staff will acknowledge receipt of emergency policies and procedures in writing; and,

If the program is not hospital based, the program will have policies and procedures for accessing services at a critical care facility.

1.15.05 A file will be maintained for each client, per admission; it will contain:

Proof of client identity;

A signed Voluntary Admission Agreement; or,

Involuntary Admission Agreement, as appropriate;

Consent to Treat Agreement must be signed prior to admission;

1. Must obtain signed, dated and timed consent, even if client is impaired by substance; and,
2. Must obtain another signed, dated and timed consent once said substance no longer impairs client.

The withdrawal risk assessment will be initiated on admission, completed and filed in the client record within four (4) hours of admission. If an emergency of the client's physical condition prevents documentation within four (4) hours, staff will explain the circumstances in the client record and obtain the information as soon as possible;

Qualified staff member(s) (physicians, registered and/or licensed practical nurses or Regional Detoxification Specialists) will perform withdrawal risk assessment; it will include:

1. Substance Use History;
2. Current Detoxification Level Determination;
3. Past psychiatric treatment;
4. Past chemical dependency treatment;
5. Significant medical history;
6. Current health status;
7. Current medications;
8. Known food allergies;
9. Known drug allergies;
10. Current living situation;
11. Current employment situation; and,
12. Current emotional state and behavioral functioning.

Completed and signed authorization(s) to release confidential information, as appropriate;

Medication records, as appropriate (In programs utilizing LPN, LPTN and/or RNs);

Personal Property Inventory, signed by staff or authorized agent, and client;

Confirmation of client receiving and understanding of handbook;

Confirmation of client receiving notice of Federal Confidentiality Regulations; to be signed when client is capable of rational communication;

A staff person, authorized by the program, will identify the client's short-term needs (based on the withdrawal risk assessment and medical history) and develop an appropriate detoxification plan (stabilization plan):

1. An RDS, LPN, LPTN, RN or MD will sign the plan;

2. The client will sign the detoxification plan, unless medically contraindicated; staff will explain the circumstances in the client record and obtain the signature as soon as possible;

3. The completed and signed detoxification plan will be filed in the client record within eight (8) hours of admission;

4. The program will review and, if necessary, revise the detoxification plan (stabilization plan) every twenty-four (24) hours or more often, should client need(s) change significantly;

5. The program will implement the detoxification plan (stabilization plan) and document the client's response to interventions in the progress notes.

1.15.06 Progress notes in detoxification will be documented every two (2) hours until stable for eight (8) hours (additional notes will be documented as appropriate) and will include:

a. The client's physical condition observed by staff (signs);

b. Client statements about the client's condition (symptoms);

Client statements about their needs;

The client's mood and behavior; and,

Information about the client's progress or lack of progress in relation to detoxification (stabilization) goals.

1.15.07 The program will have policies and procedures for accessing services at a critical care facility.

ACT 10

ACT 10

20-64-801 Definitions

As used in this subchapter:

(1) "Administrator" refers to the chief administrative officer or executive director of any private or public facility or program designed as a receiving facility or program by the Bureau of Alcohol and Drug Abuse Prevention;

(2) "Bureau" refers to the Bureau of Alcohol and Drug Abuse Prevention of the Department of Health;

(3) "Detention" refers to any confinement of a person against his or her wishes and begins either:
(A) When a person is involuntarily brought to a receiving facility or program:
(B) When the person appears for the initial hearing; or
(C) When a person on a voluntary admission is in a receiving facility or program pursuant to 20-64-810;

(4) "Evaluation" means an assessment prepared by a receiving facility to include a description of the existence and extent of the person's addiction to alcohol or drugs;

(5) "Gravely disabled" refers to a person who, if allowed to remain at liberty, is substantially likely, by reason of addiction to alcohol or other drugs, to physically harm himself or herself or others as a result of inability to make a rational decision to receive medication or treatment, as evidenced by:
(A) Inability to provide for his or her own food, clothes, medication, medical care, or shelter;
(B) An inability to avoid or protect himself or herself from severe impairment or injury without treatment; or
(C) Placement of others in a reasonable fear of violent behavior or serious physical harm to them;

(6) "Homicidal" refers to a person who is addicted to alcohol or drugs and poses a significant rick of harm to others as manifested by recent overt behavior evidencing homicidal or other violent assaultive tendencies;

(7) "Person" shall mean a citizen of the State of Arkansas who is eighteen (18) years of age or older;

(8) "Receiving facility or program" refers to a residential, inpatient, or outpatient treatment facility or program which is designed within each geographical area of the state by the bureau to accept the responsibility for care, custody, and treatment of persons voluntarily admitted or involuntarily committed to the facility or program; and

(9) "Suicidal" refers to a person who is addicted to alcohol or other drugs and by reason thereof poses a substantial risk to himself or herself as manifested by evidence of threats of, or attempts at suicide or serious self-inflicted bodily harm, or by evidence of other behavior or thoughts that create and imminent risk to his or her physical condition.

History. Acts 1989 (3rd Ex. Sess.), No. 1; 1991, No. 150, 1; 1995, No. 1268, 1.

20-64-802. Jurisdiction.

The probate courts of this state shall have exclusive jurisdiction for the involuntary commitment procedures initiated pursuant to this subchapter. The probate judge may conduct hearings pursuant to this subchapter in a receiving facility or program where they person is detained or residing at the Arkansas State Hospital or within any county of his judicial court.

History. Acts 1989 (3rd Ex. Sess.), No. 10, 2.

20-64-803. Civil immunity.

The prosecuting attorney, deputy prosecuting attorneys, the Office of the Prosecutor Coordinator, law enforcement officers, governing boards of the Bureau of Alcohol and Drug Abuse Prevention, employees of the bureau, governing boards of designed receiving facilities, and employees of designated receiving facilities and programs shall be immune from civil liability for performance of duties imposed by this subchapter.

History. Acts 1989 (3rd Ex. Sess.), No. 10 19; 1995, No. 1268, 2; 1997, No. 1246, 1.

20-64-804. Habeas corpus.

Nothing in this subchapter shall in any way restrict the right of any person to attempt to secure his or her freedom by habeas corpus proceeding as provided by current Arkansas law.

History. Acts 1989 (3rd Ex. Sees.), No. 10, 20.

20-64-805. Inspections – Procedures.

(a) To assure compliance with this subchapter, the Bureau of Alcohol and Drug Abuse Prevention, through its authorized agents, may visit or investigate any receiving program or facility to which persons are admitted or committed under this subchapter.

(b) The bureau shall promulgate written procedures to implement this subchapter on or before July 1, 1995. The provisions shall:

(1) Designate receiving facilities and programs within prescribed geographical areas of the state for purposes of voluntary admissions or involuntary commitments under this subchapter; and

(2) Establish ongoing mechanisms, guidelines, and regulations for review and refinement of the treatment programs offered in the receiving facilities and programs for alcohol and other drug abuse throughout this state.

History. Acts 1989 (3rd Ex. Sess.), No. 10, 21; 1995, No. 1268, 3.

20-64-810. Voluntary admissions.

Any person who believes himself or herself to be addicted to alcohol or other drugs may apply to the administrator or his or her designee shall be satisfied after examination of the applicant that he or she is in need of treatment and will be benefited thereby, the applicant may be received and cared for in the receiving facility or program for such a period of time as the administrator or his or her designee shall deem necessary for the recovery and improvement of the person, provided that the person agrees at all times to remain in the receiving facility or program.

History. Acts 1989 (3rd Ex. Sess.), No. 10, 3; 1995, No. 1268, 4.

20-64-811. Continued detention.

(a) If at any time the person who has voluntarily admitted himself or herself to a receiving facility or program makes a request to leave, the administrator or his or her designee may file or cause to be filed a petition for involuntary commitment.

(b) If the administrator in the subchapter for involuntary commitment and that release would place the person in imminent danger of death or serious bodily harm, the administrator or his or her designee shall file or cause to be filed a petition for involuntary commitment and shall append thereto a request for continued detention.

(c) The request for continued detention shall be verified and shall:

(1) State with particularity the facts personally known to the affiant which established reasonable cause to believe the person is in imminent danger of death or serious bodily harm;

(2) Identify the treatment facility or program in which the person is being detained; and

(3) Contain specific prayer that the person be involuntarily committed and that detention be continued.

(d)(1) The person shall be considered to be held by detention pending judicial determination of the petition for involuntary commitment and continued detention. Any person detained pending judicial determination shall, within two (2) hours of his or her request to leave the receiving facility, be provided with a copy of the petition for involuntary commitment and request for continued detention.

(2) The person shall be presented with an acknowledgment of receipt of the petition for involuntary commitment and request for continued detention. If the person refuses to sign the acknowledgment, this refusal shall be noted on the person's chart and shall be attested by two (2) eyewitnesses on a second document. An original of said attestation shall be furnished to the court. Either a signed acknowledgment or completed attestation shall be sufficient to prove personal service of the petition.

(e) The petition shall be filed and presented to a probate judge on or before 5:00 PM the next day, exclusive of week-ends and holidays, after the person makes a request to leave the receiving facility or program. Thereupon, the judge shall review the petition and request for continued detention and determine whether there is reasonable cause to believe the person meets the criteria set forth in this subchapter for involuntary commitment and whether release would place the person in immediate danger of death or serious bodily harm.

(f) If the judge determines that there is reasonable cause to believe that the person meets the criteria set forth in this subchapter for involuntary commitment and that release would place the person in immediate danger of death or serious bodily harm, the judge shall order continued detention pending a hearing to be scheduled and conducted pursuant to 20-64-821.

History. Acts 1989 (3rd Ex. Sess.), No. 10, 4.

20-64-812. Absence from treatment facility or program.

(a)(1) Treatment staff shall immediately inform the prosecuting attorney of the county where the treatment facility or program is located if, in the opinion of the treatment staff, a person who voluntarily admitted himself or herself meets the criteria for involuntary commitment set forth in this subchapter and the person has absented himself or herself from the receiving facility or program.

(2) The prosecuting attorney shall initiate an involuntary commitment under his subchapter against the person.

(3)(A) Statements made by the prosecuting attorney in furtherance of the petition shall not be deemed to be a disclosure.

(B) Statements made by the treating staff to the prosecuting attorney shall be treated as confidential, and the prosecuting attorney shall remain subject to the confidentiality requirements as set forth in state and federal law regulations.

(b) If any person shall, during a period of involuntary commitment, absent himself or herself from the treating facility or program without leave, he or she may be returned by facility or program security personnel or law enforcement officers without further proceedings. The probate courts of this state are hereby authorized to enter such orders as may be necessary to effect the return.

History. Acts 1989 (3rd Ex. Sess.), No. 10, 5; 1995, No. 1268, 5.

20-64-815. Petition for involuntary commitment.

(a) Any person having any reason to believe that a person is homicidal, suicidal, or gravely disabled may file a petition with the clerk of the probate court of the county in which the person alleged to be addicted to alcohol or other drugs resides or is detained and be represented by the prosecuting attorney or by any other licensed attorney within the State of Arkansas.

(b) The petition for involuntary commitment shall:

(1) State whether the person is believed to be homicidal, suicidal, or gravely disabled;

(2) Describe the conduct, signs, and symptoms upon which the petition is based. The descriptions shall be limited to facts within the petitioner's personal knowledge.

(3) Contain the names and addresses of any witnesses having knowledge relevant to the allegations contained in the petition; and

(4) Contain a specific prayer for commitment of the person to an appropriate designated receiving facility or program, including residential inpatient or outpatient treatment for his or her addiction to alcohol or other drugs.

(c) Personal service of the petition shall be made in accordance with the Arkansas Rules of Civil Procedure and shall include:

(1) A notice of the date, time, and place of hearing; and

(2) A notice that if the person shall fail to appear, the court shall issue an order directing a law enforcement officer to place the person in custody for the purpose of a hearing unless the court finds that the person is unable to appear by reason of physical infirmity or that the appearance would be detrimental to his or her health, well-being, or treatment.

History. Acts 1989 (3rd Ex. Sess.), No. 10, 6; 1995, No. 1268, 6; 1997, No. 1246, 2.

20-64-816. Petition for immediate detention.

(a) Any person filing a petition for involuntary commitment may append thereto a petition for immediate detention.

(b) The request for immediate detention shall be verified and shall:

(1) State with particularity facts personally known to the affiant which establish reasonable cause to believe the person is in imminent danger of death or serious bodily harm;

(2) State whether the person is currently detained in a designated receiving facility or program; and

(3) Contain a specific prayer that the person be immediately detained at a designated receiving facility or program pending a hearing.

(c) If, based on the petition for involuntary commitment and request for immediate confinement, the judge finds a reasonable cause to believe the person meets the criteria set forth in the subchapter for involuntary commitment and that the person is in imminent danger of death or serious bodily harm, the court may grant the request and order a law enforcement officer to place the person in immediate detention at a designated facility or program for treatment pending a hearing to be scheduled and conducted pursuant to 20-64-821.

(d) Personal service of the petition and order of immediate detention must be made by a law enforcement officer, who shall, at the time of service, take the person into custody and immediately deliver such person to a designated receiving facility or program.

History. Acts 1989 (3rd Ex. Sess.), No. 10, 8.

20-64-820. Appointment of counsel.

(a) If it appears to the court that a person sought to be committed is in need of counsel, counsel shall be appointed immediately upon filing of the petition. Whenever legal counsel is appointed by the court, such court shall determine the amount of the fee, if any, to be paid the attorney so appointed and shall issue an order directing the payment. The amount allowed shall not exceed one hundred fifty dollars ($150) based upon the time and effort of the attorney and the investigation, preparation, and representation of the client at the court hearings. The court shall have the authority to appoint counsel on a pro bono basis.

(b) The quorum court of each county shall appropriate funds for the purpose of payment of the attorney's fees provided for by this subchapter and upon presentment of a claim accompanied by an order of the probate court fixing the fee, the same shall be approved by the county quorum court and shall be paid in the same manner as other claims against the county are paid.

History. Acts 1989 (3rd Ex. Sess.), No. 10, 9.

20-64-821. Initial hearing – Determination – Evaluation.

(a) In each case a hearing shall be set by the court within five (5) days, excluding weekends and holidays, of the filing of a petition for involuntary commitment, with a request for continued detention or for involuntary commitment with a request for immediate detention.

(b) The person named in the original petition may be removed from the presence of the court upon finding that his or her conduct before the court is so disruptive that proceedings cannot be reasonably continued with him or her present.

(c) The petitioner shall appear before the probate judge to substantiate the petition. The court shall make a determination based upon clear and convincing evidence that the standards for involuntary commitment apply to the person. If such a determination is made, the person shall be remanded to a designated of the Bureau of Alcohol and Drug Abuse Prevention or the designated receiving facility for treatment for a period of up to twenty-one (21) days.

(d) Every person remanded for treatment shall have an evaluation within forty-eight (48) hours of detention.

(e) A copy of the court order committing the person to the designated receiving facility for treatment shall be forwarded to the designated receiving facility within five (5) working days.

History. Acts 1989 (3rd Ex. Sess.), No. 10, 10; 1991, No. 150, 3; 1997, No. 1246, 4.

20-64-822. Pleadings – Involuntary commitment.

The pleadings in each case shall be deemed to conform to the proof. The court is hereby authorized to enter orders of involuntary commitment pursuant to 20-47-201 et seq., conforming thereto.

History. Acts 1989 (3rd Ex. Sess.), No. 10, 11.

20-64-823. Filing of petition – Legal representation.

The petition may be filed by the local prosecuting attorney, an attorney representing the petitioner, or pro se. The county shall establish an indigency fund to permit the petitioner or request a court-appointed attorney by filing an affidavit of indigency. The attorney may be allowed a few of up to one hundred fifty dollars ($150). Should the probate court designate a probate judge in Pulaski County, Arkansas, to hear petitions filed for additional periods of commitment pursuant to this subchapter, the Office of Prosecutor Coordinator shall appear for and on behalf of the petitioner and the State of Arkansas before the judge, provided that the hearing is held on the grounds of the Arkansas State Hospital at Little Rock. The representation shall be a part of the official duties of the Prosecutor Coordinator. However, nothing in this section shall prevent the petitioner from retaining his or her own counsel. Thereupon, the Prosecutor Coordinator shall be relieved of the duty to represent the petitioner.

History. Acts 1989 (3rd Ex. Sess.), No. 10, 15.

20-64-824. Additional commitment.

(a) An additional forty-five-day commitment order may be requested if in the opinion of the treatment staff a person remains suicidal, homicidal, or gravely disabled.

(b)(1)(A) Any request for periods of additional commitment pursuant to this section shall be made by a petition verified by the receiving facility treatment staff.

(B) The petition for additional commitment, all rights enumerated in 20-64-817. shall be applicable.

(c)(1)(A) A hearing on the petition for additional commitment pursuant to this section shall be held before the expiration of the period of confinement.

(B) The hearing may be held in a receiving facility or program where the person is detained or residing.

(2) A copy of the petition shall be served upon the person sought to be additionally committed, along with a copy forwarded to any attorney who may have represented or may have been appointed to represent the person at the initial hearing.

(d) All testimony shall be recorded under oath and preserved.

(e) The need for additional commitment shall be proven by clear and convincing evidence.

History. Acts 1989 (3ed Ex. Sess.), No. 10, 13; 1997, No. 1246, 5.

20-64-825. Voluntary status.

(a) At any time during detention, the person may be converted to voluntary status if the person's certified substance abuse counselor files a written statement of consent with the court. The court shall dismiss the petition immediately upon the filing of said statement.

(b) If, upon evaluation, the certified substance abuse counselor determines that the person is not addicted to alcohol or drugs or would benefit by an alternative method of treatment, the counselor shall file a copy of the evaluation with the court along with a request for amendment of the court's order of detention.

History. Acts 1989 (3rd Ex. Sess.), No. 10, 12; 1991, No. 150, 4.

20-64-826. Early release.

(a) If any person is released from detention prior to the expiration of the period of commitment, the court may condition the release upon the person's compliance with outpatient treatment for the time not to exceed the duration of the commitment order and at the facility as may be specified by the court.

(b) When in the opinion of the professional person in charge of the program providing involuntary treatment under this chapter, the committed patient can be appropriately served by less restrictive treatment before expiration of the period of commitment, then the less restrictive care may be provided.

History. Acts 1989 (3rd Ex. Sess.), No. 10, 14; 1997, No. 1246, 6.

20-64-827. Appeals.

All commitment orders authorized herein shall be considered final and appealable under Rule 2 of the Arkansas Rules of Appellate Procedure.

History. Acts 1989 (3rd Ex. Sess.), No. 10, 17.

20-64-828. Presumption of competency.

No person admitted voluntarily or committed involuntarily to a receiving facility or program under this subchapter shall be considered incompetent per se by virtue or the admission commitment.

History. Acts 1989 (3rd Ex. Sess.), No. 10, 16.

20-64-829. False statement – Penalty.

Any person willfully making false statements on a petition for involuntary commitment, petition for involuntary commitment with request for continued detention, or petition for involuntary commitment with request for immediate detention, or who willfully makes false statements for the purpose of inducing another to bring such a petition, knowing the statements to be false, or with reckless disregard as to the truthfulness of the statements shall be guilty of a Class A misdemeanor.

History. Acts 1989 (3rd Ex. Sess.), No. 10, 18.

20-64-830. Liability for treatment – Rules.

(a)(1) Any person legally obligated to support a person in treatment from a receiving facility or program shall pay to the facility or program an amount to be fixed by the facility or program as the cost for treatment.

(2) The amounts shall be a debt of the obligor.

(b)(1) The Bureau of Alcohol and Drug Abuse Prevention shall promulgate rules specifying the amounts to be fixed as costs and establishing procedures for implementation of this section.

(2) The rules shall set forth costs by reference to the income and assets of the obligor.

History. Acts 1989 (3rd Ex. Sess.), No. 10, 22; 1995, No. 1268, 8.

FORMS

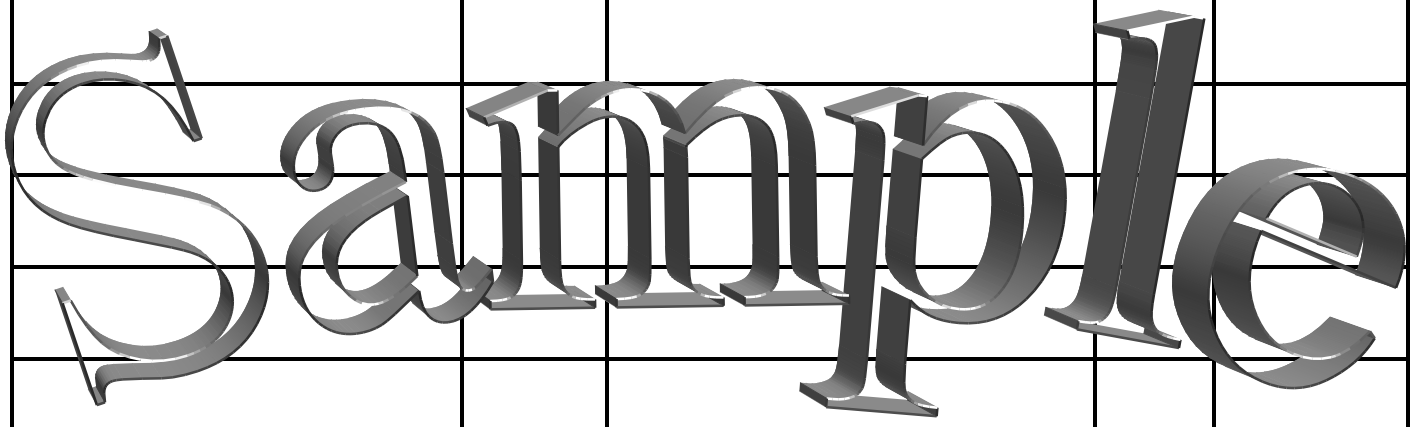
ALCOHOL AND DRUG ABUSE PREVENTION

REGIONAL ALCOHOL AND DRUG DETOXIFICATION PROGRAM

ADMISSIONS AND REFUSALS

FACILITY:_____

NAME	DATE	DISPOSITION	RDS	REFERAL



ALCOHOL AND DRUG ABUSE PREVENTION
REGIONAL ALCOHOL AND DRUG DETOXIFICATION PROGRAM
VOLUNTARY ADMISSION AGREEMENT

FACILITY: _____
IN THE MATTER OF THE VOLUNTARY ADMISSION OF

_____

VOLUNTARY ADMISSION AGREEMENT

WHEREAS, alcoholism and drug addiction are illnesses, and are problems affecting the general welfare and economy of the State, and

WHEREAS, I, _____, realize that I am an alcoholic/drug abuser and in need of treatment for alcoholism/drug abuse, I wish to admit myself to _____ for treatment of alcoholism/drug abuse for a period of not more than twenty one (21) days. I wish to further state that this voluntary admission agreement is binding and was entered into with full understanding of its meaning.

I further state that there are no charges pending against me in any court under the laws of the State of Arkansas.

_____

Signed this _____ day of _____, 20____

WITNESS _____

WITNESS _____

CONDITIONS OF ADMISSION

1. I agree to participate in all aspects of the program. If I leave the program prior to completion or if I am given a disciplinary discharge, I understand I will not be eligible for readmission for one (1) year.

2. Any alcohol/drug use or verbal/physical abuse will result in immediate discharge.

3. I understand all of my possessions will be searched upon admission and subject to search at any time while in the program. Any drugs or alcohol found during said search will be seized.

4. I understand that any illegal drugs or any item possessed in violation of the criminal laws of the United States or the State of Arkansas will be seized and delivered to law enforcement officials.

5. I will have no visitors while I am a client in this program.

6. In the event that I become homicidal, suicidal or gravely disabled and leave the premises, I authorize the Director of the facility, or his/her designee, to contact the proper authorities or persons with the intent that no harm occur to myself or others.

7. I hereby authorize the facility Director, or his appointed representative, to assist me in receiving adequate medical attention whenever the facility staff becomes aware that medical treatment may be necessary. For this service the facility will not be held medically, legally or financially responsible.

I knowingly and voluntarily consent to the above terms and conditions. Each item has been read by me, or has been explained to me, and is understood by me. No one has attempted to force me to sign this document and no threats of any kind have been made to me by any person employed by or acting under the direction of this facility.

_____ _____

Client's Signature Date

_____

Witness

CONSENT FOR THE RELEASE
OF CONFIDENTIAL INFORMATION

I,_____,authorize
(Name of patient)

_____
(Name or general designation of program making disclosure)

to disclose to _____
(Name of person or organization to which disclosure is to be made)

the following information:

_____
(Nature of the information, as limited as possible)

_____

_____

The purpose of the disclosure authorized herein is to:

_____
(Purpose of disclosure, as specific as possible)

_____

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

_____
(Specification of the date, event, or condition upon which this consent expires)

_____

Dated:_____ _____
Signature of Participant

CONSENT FOR THE RELEASE
OF CONFIDENTIAL INFORMATION:
CRIMINAL JUSTICE SYSTEM REFERRAL

I, _____, hereby consent to
(Name of defendant)

communication between _____and
(treatment program)

_____
(court, probation, parole, and/or other referring agency)

The purpose of and need for the disclosure is to inform the criminal justice agency(ies) listed above of my attendance and progress in treatment. The extent of information to be disclosed is my diagnosis, information about my attendance or lack at treatment sessions, my cooperation with the treatment program, prognosis, and
_____

_____

_____

I understand that this consent will remain in effect and cannot be revoked by me until:

there has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment, or

_____
(other time when consent can be revoked)

_____
(other expiration of consent)

I also understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records and that recipients of this information may disclose it only in connection with their official duties.

_____

ALCOHOL AND DRUG ABUSE PREVENTION
REGIONAL ALCOHOL AND DRUG DETOXIFICATION PROGRAM

CLIENT'S PERSONAL PROPERTY

FACILITY_____

DATE:_____

I hereby agree to assume full responsibility upon admission for my funds, personal property and clothing.

I understand that _____cannot be responsible
(facility)
for my funds, clothing and other personal items during my stay in the facility. I further understand that all items left in the facility at the time of my discharge will be disposed of as the facility staff sees fit.

Signature of Client: _____

Witness: _____

Date:_____

The amount of money I had when I came to this facility was: $_____

The following is a list of items I had in my possession when I came to this facility:

_____

_____

Signature of Client: _____

Witness: _____

Date:_____

ALCOHOL AND DRUG ABUSE PREVENTION
REGIONAL ALCOHOL AND DRUG DETOXIFICATION PROGRAM

FACILITY:

NAME:

DOB:

SS #:

VITAL SIGNS

DATE	TIME	T	P	R	B/P	COMMENTS	INITIALS

Alcohol and Drug Abuse Prevention

Regional Alcohol and Drug Detoxification Program

NAME:

DOB:

SS #:

Regional Detoxification Specialist Notes

Date	Hour	Date and Sign All Notes With First and Last Name

ALCOHOL AND DRUG ABUSE PREVENTION

REGIONAL ALCOHOL AND DRUG DEXTOXIFICATION PROGRAM

ADMISSION RECORD (please print)

Name (Last, First, Middle)	Race/Sex	Phone #		

Street Address	City	County	DOB	Age

SS#	Marital Status	Correspondent/Next of Kin	Phone #

Date of Admission	Time of Admission	Type of Admission (circle)	
		VOL	Medical Emergency

_____ First Admission

_____ Readmission _____# of Prior Admissions _____ Last Discharge

Monthly Income (list sources)	Amount		
	Total Amount		
Health Insurance:			

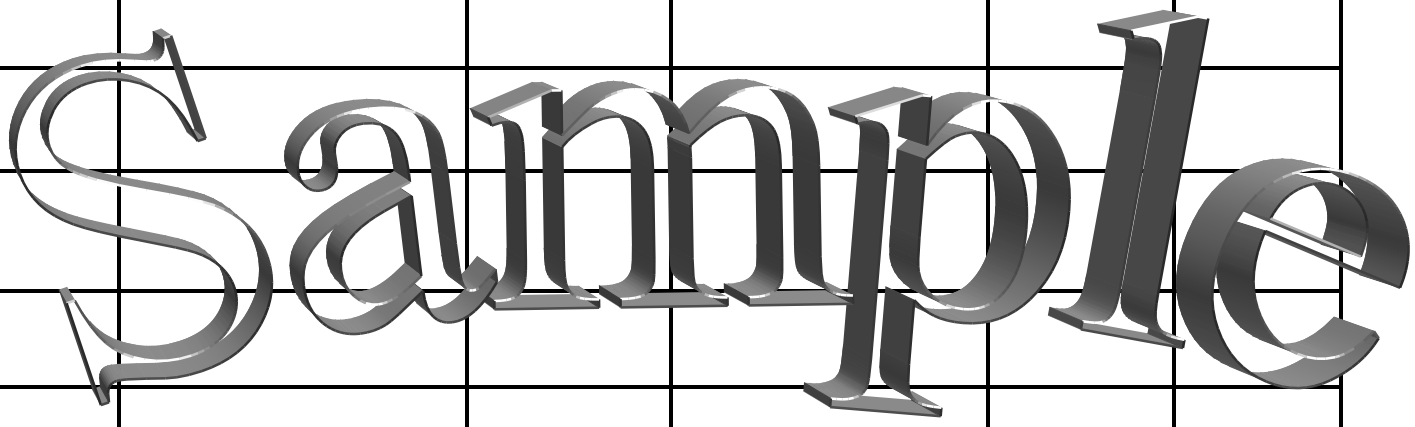
SAMPLE STABILIZATION PLANS

No.	PROBLEM (Medical, Behavioral, ED/Voc Financial, Occupational/ Lifestyle, Functional Skills, Family)	GOAL (must be specific)	INTERVENTIONS OBJECTIVE & METHOD (must be measurable and include Frequency)	STAFF & TARGET DATE
1.	Impaired safety due to (type of drug) Withdrawal manifested by (list symptoms). This can be tailored to the specific symptoms manifested. *Sample: Impaired safety due to alcohol Withdrawal manifested by [illegible], tremors, diaphoresis.*	Patient will experience safe withdrawal from _____ __. *Patient will experience safe withdrawal from alcohol.*	1. Monitor VS at least 4h x 75h, PRN 2. _____ detox protocol per MD order Ensure adequate safety, rest, nutrition: (Address your safety etc precautions here *1. Monitor VS at least q [illegible]h, 2. [illegible] detox protocol per MD order Ensure adequate safety, rest, nutrition*	
2.	Impaired safety due to (type of drug). withdrawal manifested by (list symptoms). This can be tailored to the specific symptoms manifested. ***Sample: Patient unable to identify relationships of tremors to alcohol withdrawal or ulcers (if ulcers are admitting Dx).***	Patient will verbalize understanding of relationship between (symptoms) and (alcoholism/addiction). Patient will verbalize understanding of need for sobriety after discharge. *Patient will verbalize understanding of relationship between tremors, ulcers and alcoholism.*	Include above, and 1. Chemical Dependency Consult Provide patient with education about _____ ____. (list your educational materials) *1. Provide patient with education about alcoholism: CD Consult, provide with AA meeting schedule on discharge.*	

STABLIZATION PLAN

(Detoxification Plan)

PROLEM #	**PROBLEM** (Medical, Behavioral, Ed/ Voc Financial, Occupational/ Lifestyle, Functional Skills, Family)	**Goal** (must be specific)	**INTERVENTION, OBJECTIVES & METHOD** (must be measurable and include frequency)	Responsible Person or Discipline	Date Goal Met or Revised



Client Signature _____ RDS Signature _____

Sample Discharge Plan
(Aftercare Plan)

Client Name: ____ Date Plan Initiated: _______________
Initiated By: _____________________

This is started on admission and updated as more patient information is obtained.

Patient will verbalize understanding of need for sobriety after discharge.

Patient will have received A.A. (NA/CA) meeting schedule.

Patient will follow through with _________________________________ on (date) ______________________________ to review status.

Patient agrees to follow through with ____________________________ if [illegible] to stop (drinking[illegible]) in 30 days.

It is a good idea to have a “discharge [illegible]et” for chemically dependent clients which [illegible] include [illegible] meeting schedule[illegible] (or [illegible] CA), Al0Anon meeting schedule [illegible] their “significant others”; information handout[illegible] (available at [illegible] cost [illegible]A.A.), listings of alcohol and drug mental health resources and treatment facilities (in and outpatient).

Date Initiated _______________

Client Signature ____ Date ____________________________

RDS Signature ____ Date ____________________________

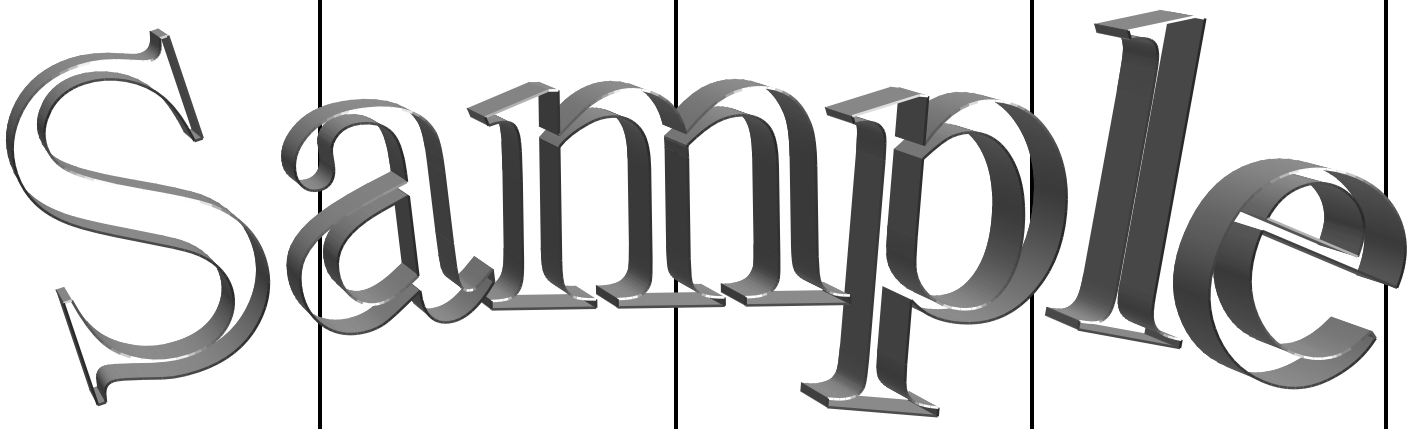
DISCHARGE PLAN

(Aftercare Plan)

Client Name _____ Date Initiated _____

Initiated By _____

Client Need	Established Goal	Objective	Target Date



Date Initiated _____

Client Signature _____ Date _____

RDS Signature _____ Date _____

REGIONAL ALCOHOL AND DRUG DETOXIFICATION

WITHDRAWL RISK ASSESSMENT

General and Contact Information

Name:_____

Address: _____

_____

City State Zip Code

Phone Number:_(_____)_____

Race: (Circle one) White Black/ African-American Hispanic

Native American/ Indian Asian/Pacific Islander Other

Sex: (Circle one) Male Female Date of Birth: _____/_____/_____

In case of emergency, contact: _____

Name

_____ _____

Phone Number Relationship

Date of Admission:_____/_____/_____ Time of Admission: ___:____ AM PM

Type of Admission: Voluntary Court Order

Vital Signs at Initial Intake:

Blood pressure_____/_____ Pulse _____ bpm

Respirations _____ Temperature _____

Substance Abuse History

Current substance (s) abused:_____

Length of use:_____

Amount used daily:_____ Amount used last:_____

Time of last use:_____:_____ AM PM

Method of use: (Circle one) Oral IV (inject) Inhale (smoke) Nasal (snort) Other

Prior Detox/Treatments: _____Yes _____No

If yes, how many prior admissions and where were the admissions:_____
_____
_____
_____

How many prior admissions/treatments were completed_____

Family History

Does anyone in the client's immediate (blood) family have or has any[illegible] had a substance abuse problem?
_____ Yes _____ No

Have there been any deaths or departures (divorces, separations, displacements of children, etc.) from the family institutions? _____ Yes _____ No

Social History

Marital Status**:** (Circle one) Single Married Divorced Widowed Separated

Any children? _____ Yes _____ No List age (s)_____

Who has parenting rights/responsibilities?_____

Have you moved at any time in the past year? _____Yes _____No

Legal History

Does the client have a valid driver's license? _____Yes _____No

Has the client ever been arrested? _____Yes _____No

If so, for what? (List year and reason)

_____

_____

Educational History

Did client complete high school and obtain a diploma? _____Yes _____No

If not, what was the highest grade completed? _____

Has client attended college or vocational technical school? _____Yes _____No

Does client have any desire or plan of continued or future education? _____Yes _____No

Occupational History

Employment Status: Employed Unemployed

Occupation:_____

Monthly Family Income**: $**_____

Has the client ever been terminated or disciplined as a result of substance abuse?
_____Yes _____No

Medical History

Does the client have any medical problems? _____Yes _____No (Please describe)

_____

Is the client currently taking any medications? _____Yes _____No (Please list)

_____

_____

Did the client present with any medications in his/her possession? _____Yes _____No

_____

_____

Current health status: _____Poor _____Fair _____Good

Does the client currently have any overriding health problems ? _____Yes _____No

_____

_____

Psychological and Behavioral History

Has the client ever been diagnosed and/or treated for any psychological or emotional problems? _____ Yes _____ No If yes, please list diagnosis and year and whether client was an outpatient or inpatient.

_____

_____

_____

What medications were prescribed to the client for the psychological/emotional problem? Please list name(s) of medications and length of use.

_____

_____

_____

Outcome of Evaluation

This client is assessed as being in: (Circle one)

____Mild Withdrawal ____ Moderate Withdrawal ____ Severe Withdrawal

Client admitted to:

_____ Observational Detox _____ Residential Treatment

_____ Denied Admission (List reason)

Reason for Denial: _____ Under 18 years of age
_____ Client is belligerent or combative
_____ Client has overriding medical problems
List problem(s)_____
_____ Other _____
_____

Notes:_____

_____

_____

_____

OFFICE OF ALCOHOL AND DRUG ABUSE PREVENTION
REGIONAL ALCOHOL AND DRUG DETOXIFICATION PROGRAM
ADMISSION ASSESSMENT & WITHDRAWAL RISK ASSESSMENT FORM

PATIENT: _____ **DATE:** _____ **TIME:** _____

ADMISSION VITAL SIGNS: **TEMP:** _____ **PULSE:** _____ **RESPS:** _____ **B/P:** _____**SITE:** _____

NAUSEA AND VOMITING 0 no nausea or vomiting 1 occasional nausea, no vomiting 2 mild nausea, no vomiting 3 nausea, dry heaves 4 constant nausea, occasional vomiting 5constant nausea, frequent dry heaves/vomiting	**DIARRHEA** 0 none 1 occasional (1 episode /week) 2 mild (once daily) 3 moderate (2-4 episodes daily) 4 severe (more than 4 episodes /day	**TACTILE DISTURBANCES-** Ask patient if they feel any itching, burning, pins/needles sensations or bugs crawling on or under their skin Observation- 0 none 1 mild itching, pins/needles, burning/numbness 2 moderate itching pins/needles, burning/numbness 3 mild-moderate hallucinations 4 severe hallucinations 5 extremely severe hallucinations 6 continuous hallucinations
TREMORS-Observe patient with arms extended and fingers spread apart. 0 none 1 not visible, but can be felt fingertip to fingertip 2 mild, visible 3 moderate, with patient's arms extended 4 moderate, patient's arms NOT extended 5 severe, patient's arms extended 6 severe, patient's arms NOT extended	**AUDITORY DISTURBANCES-**Ask patient if They are aware of sounds around them. Are they harsh? Do they frighten or disturb the patient? Ask "Are you hearing things you know are not there"? -Observation 0 none 1 very mild harshness or ability to frighten 2 mild harshness or ability to frighten 3 moderate harshness, ability to frighten 4 moderate to severe hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations	**VISUAL DISTURBANCES-**Ask "Does light seem too Bright? Does it hurt your eyes? Are you seeing odd Colors? Are you seeing things disturbing you or that you know are not there 0 1 mild sensitivity to light 2 sensitivity 3 moderate sensitivity to light 4 moderately severe sensitivity hallucinations 5 severe hallucinations 6 extremely severe hallucinations 7 continuous hallucinations
ANXIETY-Ask " Do you feel nervous? –Observe 0 no anxiety, at ease 1 mildly anxious 2 moderately anxious, guarded (anxiety inferred) 3 acute panic state- (as seen in severe delirium or acute schizophrenic reactions.)	**PAROXYSMAL SWEATING-** 0 none visible 1 barely perceptible, palms moist 2 beads of sweat obvious on forehead 3 clothing damp, sweat on forehead 4 patient drenched in sweat	**HEADACHE/FULLNESS/NUMBNESS-** Does your head feel different? Does it feel like there is a rubber band around your head? Do not rate for dizziness or lightheadedness. Otherwise, rate for severity. 0 none 1 very mild 2 mild 3 moderate 4 moderately severe 5 severe 6 extremely severe
AGITATION—Observation 0 normal activity, calm 1 somewhat more than normal activity 2 moderately fidgety and restless 3 paces back and forth during interview 4 constantly thrashing about 5 becoming aggressive or violent	**SLEEP DISTURBANCES-**Ask " Are you having problems sleeping? Do you have dreams When sleeping? Nightmares? Do the dreams/ nightmares ever wake you up? 0 none 1 occasional (once a month) 2 sometimes (weekly) 3 frequently (more than once a week) 4 every night 5 every time you sleep	**ORIENTATION/CLOUDING OF SENSORIUM-**Ask "What day/year is this? Where are you? Who am I? Why are you here?" Ask patient to do serial additions (7+7+7…). 0 oriented and can do serial additions 1 can't do serial additions or is uncertain about day/date 2 disoriented for date by no more than 2 days 3 disoriented for date by more than 2 days 4 disoriented for place and/or person 5 completely disoriented

Total Score_____
Raters Initials_____
Maximum Possible Score 63

SIGNS OF INTOXICATION OR WITHDRAWAL_____
_____
_____
_____

NOTE: Patients who score greater than _____should be referred for medical treatment.

GENERAL AND CONTACT INGFORMATION

SCREENING LOCATION: ___________________ DATE /TIME OF ADMISSION: _________________ TYPE OF ADMISSION: _____________
REASON FOR ADMISSION____
CLIENT NAME: ____ GENDER: ___________ RACE: ______________ DOB: ____________
SSN: _____________________________ MEDICAID #: ________________________ MEDICARE#: ________________________
OTHER INSURANCE: NAME:___________________ADDRESS:_______________________________ POLICY #: ___________________
CLIENT STREET ADDRESS: ______________________________ CITY: ____________________ STATE: _______ ZIP: ________________
APARTMENT NUMBER: ____________ COUNTY: _____________________________
HOME PHONE: ________________________ WORK PHONE: _____________________ OTHER PHONE: _______________
REFERRED BY: _______________________________________TITLE/PHONE: ___________________________________
REFERRAL AGENCY: ____
EMERGENCY CONTACT: NAME: ____________________________ RELATIONSHIP: __________________ PHONE: ____________________

BEHAVIORAL MANAGEABILITY

☐ Client does not appear to be assaultive or threatening to a degree that cannot be managed by this DETOX facility.
Go to next section.

☐ Client appears assaultive or threatening to a degree that cannot be managed by this DETOX facility.
Explain nature of behavior and actions taken below. Include names, agencies, phone numbers, and titles of persons notified for client referral. Also, if applicable, include name and title of person who took client into custody and note the time of occurrence. **You must sign, date and put your credentials as staff member completing this section**.

____
____
____
____

SUBSTANCE USE & INTOXIFICATION

Client is currently in a Methadone Maintenance Program: ☐ Yes ☐ No
If yes, Name of clinic_____________________ Amount______________, Last Dose__________________
End interview at this time and notify nurse on call.

USAGE PATTERN IN LAST 30 DAYS (STARTING WITH DRUG OF CHOICE)

SUBSTANCE	AMOUNT/LAST USE	FREQUENCY	METHOD	AGE AT FIRST USE
☐ Alcohol ☐ Amphetamine ☐ Benzodiazepine ☐ Cannabis ☐ Cocaine/Crack ☐ Ecstasy ☐ Hallucinogens___________ ☐ Opiates_______________ ☐ Solvents ______________ ☐ Methadone		☐ Everyday ☐ ____days a week ☐ ____days a month ☐ Other__________	☐ Oral ☐ IV (inject) ☐ Inhale (smoke) ☐ Nasal (snort) ☐ Other_____________	
☐ Alcohol ☐ Amphetamine ☐ Benzodiazepine ☐ Cannabis ☐ Cocaine/Crack ☐ Ecstasy ☐ Hallucinogens___________ ☐ Opiates_______________ ☐ Solvents ______________ ☐ Methadone		☐ Everyday ☐ ____days a week ☐ ____days a month ☐ Other__________	☐ Oral ☐ IV (inject) ☐ Inhale (smoke) ☐ Nasal (snort) ☐ Other_____________	
☐ Alcohol ☐ Amphetamine ☐ Benzodiazepine ☐ Cannabis ☐ Cocaine/Crack ☐ Ecstasy ☐ Hallucinogens___________ ☐ Opiates_______________ ☐ Solvents ______________ ☐ Methadone		☐ Everyday ☐ ____days a week ☐ ____days a month ☐ Other__________	☐ Oral ☐ IV (inject) ☐ Inhale (smoke) ☐ Nasal (snort) ☐ Other_____________	
☐ Alcohol ☐ Amphetamine ☐ Benzodiazepine ☐ Cannabis ☐ Cocaine/Crack ☐ Ecstasy ☐ Hallucinogens___________ ☐ Opiates_______________ ☐ Solvents ______________ ☐ Methadone		☐ Everyday ☐ ____days a week ☐ ____days a month ☐ Other__________	☐ Oral ☐ IV (inject) ☐ Inhale (smoke) ☐ Nasal (snort) ☐ Other_____________	

MOTIVATION FOR TREATMENT

What brought you here today? _____

Why now? _____

What difficulties/worries have you had in relation to your drinking and/or drug use?

_____
_____
_____
_____

In what ways do you think that you are other people have been affected by your drinking and/or drug use?

_____
_____
_____
_

What do you think will happen if you don't do something about your drinking and/or drug use?

_____
_____
_____
_____

DRUG USE ASSESSMENT

Have you ever overdosed? _____Yes_____No Did you intend to harm yourself? _____Yes _____

How many times have you overdosed? _____ Within the last 90 days? _____ How many times was alc olved? _____,

Which drugs were involved? _____

Have you ever had seizu s as a re ult f withd w from d gs alcoh ? _____Y _____lo

If yes to any of the above, when di the last epi od occur? _____

Have you ever injected? _____ If s , h w long av you bee njecting? _____ Age o st dru _____

Where do you inject? _____ How o n r da w k? _____

Any problems from inj cting? (ne asses es/ov rd ?) _____

Do you share nee e _____ Have you ever shared? _____ H many times in the st 4 week

_____

ALCOHOL USE ASSESSMENT

How often do you drink alcohol?_____ Over the last 7 days, how many drinks (units) would you say you've had_____

Where do you usually drink?_____ With whom?_____

How long have you been drinking this way?_____ Your age when you first started drinking?_____

How much do you spend on alcohol/month?_____ What are your concerns about this?_____

_____
_____

Have you ever had an episode of Delirium Tremens? _____Yes _____No

How long can you remain dry without discomfort? (check client for physical withdrawal symptoms)

_____

PREVIOUS TREATMENT

Have you ever been admitted for any detoxification services and/or treatment services in the past? _____Yes _____No

If yes, which facility(ies) and what date(s)? _____

_____

How many DETOX services and/or treatments have you completed? _____

How many DETOX services and/or treatments did you leave prior to completion? _____

What were the reasons for leaving treatment? _____
_____
_____
_____

Have you had any significant periods of abstinence? _____Yes _____No If yes, how long? _____

How did you manage this?

_____
_____
_____
_____

LEGAL HISTORY

Do you have a driver's License? _____Yes _____NO

Do you have previous convictions or legal problems? ______Yes ______No

Are any of your legal problems related to drug use and/or drinking? ________Yes _______No

What is the nature and date(s) of the offence (s)?
____
____
____

Do you have any legal issues pending? __________Yes ________No

- ☐ Probation/Parole
- ☐ Community Sentence
- ☐ Court case pending
- ☐ Fines pending
- ☐ Drug Court
- ☐ Court ordered treatment

What is your attitude toward current/past offences? ____

FAMILY/SOCIAL HISTORY

GENOGRAM ☐ Male O Female ==Married ## Divorced/Separated ..... Co-habiting X Deceased

Do you [illegible] alone? ______Yes ______No, [illegible] with______________________________

How many ch[illegible]en [illegible] you [illegible] ______ Chil[illegible] ______ Do [illegible] cust[illegible] ______Y[illegible] ________No

[illegible] ring for the children while you are in treatment?______________________________

[illegible]s there a family history of alcohol/drug use? _______Yes _______No
Explain:
____
____

What was it like growing up in your family?
____
____
____

Were there any significant events, traumas that occurred in your childhood that may be important to know about?
____
____

Have there been any deaths or departures (divorces, separations, displacements of children etc.) from the family? ______Yes ____No If yes, were any related to alcohol/drug use? _______Yes _____No

Do you engage in unprotected sex? _____Yes ____No If so, How often do you change partners? ____________________

Relationship Status: ________________________ Duration? __________ Any problems? (Domestic violence)_______________________

Does your partner/significant other use alcohol/drugs? _______ Yes _______No

Have you moved any time in the past year? _______Yes _______No

Have you found yourself not wanting to participate or enjoying social activities you liked in the past? _____Yes ______No

Has the way you participate in or enjoy social activities changed? ________Yes _______No

Do you have social support networks/friendships? _______Yes _______No

EDUCATION/EMPLOYMENT HISTORY

What was the highest grade you completed in school?_____ College degree?_____

Are you currently employed?_____ If so, where?_____ How long?_____ _____

If you are not employed, how do you pay your bills? _____

MEDICAL HISTORY

If female, are you pregnant? _____Yes _____No If yes, how many months?_____

Do you currently have any physical illnesses or emotional/medical problems that affect your life? _____Yes _____No If yes, please de-
scribe._____
_____
_____
_____
__

Are you currently taking any prescribed or over the counter medications (include any herbal remedies)? _____Yes _____NO

MEDICATION	DOSAGE	FREQUENTCY	TIME OF LAST DOSE

How would you describe your current health status? _____ (poor, fair, good, excellent)

Does the client have any **untreated** injuries or health problems? (Overriding medical problems)_____Yes _____

IF YES, REFER TO MEDICAL FACILITY

- ☐ Broken bones
- ☐ Diabetes (New onset or Uncontrolled)
- ☐ Bleeding wound(s)
- ☐ Nosebleed (uncontrolled)
- ☐ Chest pain
- ☐ Distended abdomen
- ☐ Seizure disorder
- ☐ Excessive bruising (especially to head and face area
- ☐ High blood pressure
- ☐ Jaundice
- ☐ Excessive/projectile vomiting (esp. blood tinged)
- ☐ Other _____

FOOD AND DRUG ALLERGIES _____Yes _____No

I AM ALLERGIC TO:	MY REACTION TO THIS SUBSTANCE IS:

PREVIOUS TESTS

Have you been tested for:

HIV/AIDS ___Yes ____No
Gamma GT ____Yes ___No
Tuberculosis ____Yes ____No
Hepatitis B ____Yes ____No
Hepatitis C ____Yes ____No

Are you interested in being tested? _____Yes _____No

PSYCHOLOGICAL AND BEHAVIORAL HISTORY

Do you currently have any emotional problems or concerns? _____Yes ____No

Have you ever been treated for any type of psychological or emotional problems? ____Yes ____No
(If yes, please list the diagnoses, year diagnosed and whether treatment was inpatient or outpatient)

_____
_____
_____
_____

Have you ever attempted suicide? _____Yes _____No If yes, how many times_____

Are you currently suicidal or have you had suicidal thoughts recently? _____Yes ____No

Explain: _____
_____
_____

Have you ever deliberately self-harmed? _____Yes _____No

Have you ever tried to harm or kill anyone else? _____Yes ____No

Do you currently have thoughts of wanting to harm or kill others? _____Yes ____No
Explain: _____
_____

What are your expectations and goals of detox treatment _____
_____
_____

Immediate advice given, concerns addressed, referrals to other support services (mental or medical health, urine/ toxicology tests taken, etc._____
_____
_____

Client's mental state at time of interview (i.e. calm/cooperative, hostile, anxious, alert, drowsy, speech clear/slurred, thought patterns, evidence of psychotic symptomology, orientation, insight:

_____
_____
_____

SUMMARY

This client is assessed as having:

NO WITHDRAWL (No signs or symptoms of current intoxication or withdrawal)

MILD WITHDRAWAL (Mild or transient signs or symptoms with no impending threat to health and no history or evidence of potential significant medical complications).

MODERATE WITHDRAWAL (moderate signs of symptoms representing a threat to health but manageable through support, observation, reassurance, daily medical monitoring and management on an ambulatory basis with self-administration of fluids, foods, food supplements and prescribed medications).

SEVERE WITHDRAWAL (Presenting signs and symptoms represent a serious threat to health or life which can only be managed in an acute care facility, or there is evidence of significant medical complications requiring hospital assessment/treatment or acute inpatient management and monitoring). **REFER CLIENT TO MEDICAL FACILITY.**

◊ Consider referral to Medical detox
◊ Appropriate for Observational Detox
◊ Refer for psychiatric assessment
◊ Refer for medical assessment

RADD ASSESSMENT

Date ___/___/___Time: ____:_____ AM PM Location:_____

Name: _____
Last First Middle

SSN: _____ DOB:_____/_____/_____ Male Female

Street Address: _____

City: _____ State/Zip: _____

County: _____ Phone #: ( ) _____

List any document copied for Confirmation of Identity : _____

African American American Indian/Alaska Native Asian/Pacific Islander

Caucasian Hispanic Multi-Race _____

Allergies: _____

Referred for assessment of withdrawal risk by: _____
_____
_____

If not referred for withdrawal risk assessment, the applicant is not appropriate for Regional Alcohol and Drug Detoxification Services. **STOP!** Make appropriate referral(s) and specify alternative(s) offered to applicant:
_____
_____
_____
_____

If court referral, is Court Order present? _____

Comments: _____
_____
_____

_____ _____
Staff Signature Staff Title

SUBSTANCE USE HISTORY

Is applicant currently on Methadone Maintenance Program: Yes No
Amount:_____ Last Dose: _____

Name of Clinic _____

If yes, **STOP!** and follow policy and procedure for your facility.

Enter number in box to indicate order of use preference. **Substance**	**First Use**	**Amount Last Use**	**Last 30 Day Pattern of Use** Include route, amount, frequency, longest abstinence
Alcohol (any use)			
Amphetamines			
Cannabis			
Cocaine			
Heroin/other opiates			
Barbiturates			
Sedatives/ hypnotics/ tranquilizers			
Hallucinogens			
Caffeine			
Nicotine (tobacco)			

*Have you taken any other substances within the last 48 hours that you have not been asked about? (If **yes**, use back of form.)

RISK ASSESSMENT

(Continued)

YES NO Do you have chills or fever now?

YES NO Are you having any stomach pain?

YES NO Are you having any chest pain?

YES NO Are you having any head pain?

YES NO Have you had trouble breathing in the past three days?

YES NO Have you fallen or been injured in a fight or accident in the past week?

YES NO Have you hit/been hit on the head or lost consciousness in the past week?

YES NO Have you had any bleeding from the rectum, black stools, vomiting with blood in it, or what looks like coffee grounds within the last week?

YES NO Have you had any seizures, or awakened on the floor or the ground without knowing how you got there? *If on medication, applicant must bring supply.*

YES NO Have you had any heart problems? *If on medication, applicant must bring supply.*

YES NO Have you had any problems with high blood pressure? *If on medication, applicant must bring supply.*

YES NO Have you been told you have diabetes? *If on medication, applicant must bring supply.*

YES NO Are you having thoughts of killing yourself at this time?

YES NO Do you have a plan for how you would kill yourself?

YES NO Are you having thoughts about killing someone else?

YES NO Are you currently hearing voices or seeing things that you know are not there?

YES NO Applicant is threatening or aggressive to a degree that cannot be managed in this facility?

If ANY indicators are marked "YES,"

Applicant must have medical and/or psychiatric clearance prior to admission, or currently be under the care of a physician for stated condition.

Applicant must currently have applicable medications with them at admission.

Applicant must be currently on those medications.

If applicant does meet criteria…**STOP**…make appropriate referral(s); specify alternative(s) offered to applicant.

_____

_____

____

Time: _____:_____ AM PM

Date: _____

_____

Staff Signature

_____

Staff Title

Initial Assessment and/or Ongoing Monitoring

Client: _____ Date: _____

Blood Pressure: _____/_____ Temp: _____ Pulse _____ Respirations _____

Breathalyzer Reading _____

Tremor – Observe: *with arms extended and fingers spread apart*
0 – no tremor
1 – no tremors visible, but can be felt fingertip to fingertip
2-
3-
4- moderate, with client's arms extended
5-
6-
7- severe, even with arms not extended

Nausea and Vomiting – Ask: *Do you feel sick to your stomach? Have you vomited?* (Also indicate what you obs[illegible]ating)
0- [illegible]o nausea &/or vomiting
1- mild nausea with no vomiting
2-
3-
4- intermittent nausea with dry heav[illegible]
5-
6-
7- constant nausea, frequent dry heaves [illegible]vomi[illegible]

Paroxysmal Sweat[illegible] Observe:
0- no sweat [illegible]
1- barely perceptible sweating, palms moist
2-
3-
4- beads of sweat obvious on forehead
5-
6-
7- drenching sweats

Anxiety – Ask: *Do you feel nervous?* (Also include what you observe in rating)
0- no anxiety, at ease
1- mildly anxious
2-
3-
4- moderately anxious, or guarded, so anxiety is inferred
5-
6-
7- equivalent to acute panic states as seen in severe delirium or acute schizophrenic reactions

Agitation – Observe:
0- no sweat
1- somewhat more than normal activity
2-
3-
4- Moderately fidgety and restless
5-
6-
7- Paces back and forth during most of the interview, or constantly thrashes about

Tactile Disturbances – Ask: *Have you had any itching, pins & needles sensations, any burning, any numbness, or do you feel bugs crawling on or under your skin?* (Also include what you observe in rating)
0- none
1- slight itching, pins & needles, burning or numbness
2- mild itching, pins & needles, burning or numbness
3- moderate itching, pins & needles, burning or numbness
4- moderately severe hallucinations
5- severe hallucinations
6- extremely severe hallucinations
7- continuous hallucinations

Auditory Disturbances – Ask: *Are you more aware of sounds around you? Are they harsh? Do they frighten you? Are you hearing anything that is disturbing to you? Are you hearing things you know are not there?* (Also include what you observe in rating)
0- not present
1- very mild harshness or ability to frighten
2- moderate harshness or ability to frighten
3- moderately severe hallucinations
4- moderately severe hallucinations
5- severe hallucinations
6- extremely severe hallucinations
7- continuous hallucinations

Visual Disturbances – Ask: *Does the light appear to be too bright? Is its color different? Does it hurt your eyes? Do you see things you know are not there?* (Also include what you observe in rating)
0- not present
1- very mild
2- very mild harshness or ability to frighten
3- moderately severe hallucinations
4- moderately severe hallucinations
5- severe hallucinations
6- extremely severe hallucinations
7- continuous hallucinations

Headache, Fullness in Head – Ask *Does your head feel different? Does it feel like there is a band around you head? Do not rate for dizziness or lightheadedness. Otherwise rate severity.*
0- not present
1- very mild
2- mild
3- moderate
4- moderately severe
5- severe
6- very severe
7- extremely severe

Orientation & Clouding of Sensorium – Ask: *What day is this? Where are you? Who am I?*
0- oriented and can do serial additions
1- cannot do serial additions or is uncertain about date
2- disoriented for date by no more than 2 calendar days
3- disoriented for date by more than 2 calendar days
4- disoriented for place &/0r person

_____**Total Score**
(67-maximum possible score)

_____
Rater's Signature

Physical and/or Psychiatric Indicators for Determination of Detoxification Level

Attempts at Detox: _____

_____

_____

Have you ever experienced any of the following symptoms when you attempted to stop using?
(Circle any that apply)

1-Restlessness	1-Irritability	1-Anxiety	1-Anorexia	***Note***
1-Nausea	1-Vomiting	1-Diarrhea	1-Constipation	0-9…Observation in Social Detox
1-Muscle Cramps	1-Headache	1-Craving	1-Difficulty sleeping	10-19…Social Detox with Medical Support
2-Tremors	2-↑ heart rate	2-↑ blood pressure	2-↑ temperature	
1-Profound sweating	1-Intense nightmares	2-Impaired concentration	1-Impaired memory	20 & higher… Medical Detox
2-Impaired judgment	2-Sensitivity to sound	3-Delirium Tremens	3-Hallucinations Tactile	
3-Delusions *(usually paranoid)*	3-Grand Mal Seizures	Duration___	Visual	
			Auditory	
			Other:_____	

Yes	No	Have you had any problems, other than those listed above, when you have tried detoxification in the past?
Yes	No	Are you vomiting up juice, broth or water when you drink now?
Yes	No	Do you think there is any chance you may be pregnant?
Yes	No	Have you been told by a health professional that you have tuberculosis?
Yes	No	Have you been told by a health professional that you have hepatitis?
Yes	No	Have you been told by a health professional that you are HIV positive or have AIDS?
Yes	No	Have you been told by a health professional that you have liver problems?
Yes	No	Have you taken Antibuse in the last 48 hours? ("Yes" does not disqualify applicant)
Yes	No	Do you have trouble standing or walking?
Yes	No	Do you feel someone wants to hurt you?
Yes	No	Do you carry a gun, knife or other weapon to protect yourself?
Yes	No	Does it bother you if people get close to you or touch you?

If ANY indicators are marked "YES," and/or history of withdrawal symptoms with a '2' or '3' applicant is not appropriate for Observational Services.

Current Medications: (Include over-the-counter and prescription medications)

Drug: _____ Dose:_____
Frequency: _____ Last Taken:_____ Rx#:_____

Drug: _____ Dose:_____
Frequency: _____ Last Taken:_____ Rx#:_____

Drug: _____ Dose:_____
Frequency: _____ Last Taken:_____ Rx#:_____

Drug: _____ Dose:_____
Frequency: _____ Last Taken:_____ Rx#:_____

Drug: _____ Dose:_____
Frequency: _____ Last Taken:_____ Rx#:_____

Did applicant bring adequate supply of above medications? _____

Yes No Are you allergic to any food or medication?

Yes No Have you been hospitalized in the last year for any reason?

Yes No Have you ever had surgery?

Yes No Have you ever thought of hurting or killing yourself? If yes, how often do you have thoughts of killing self?)
_____ Rarely have thoughts
_____ Sometimes have thoughts – not now
Often have thoughts – not now

Yes No Have you ever received care in a psychiatric hospital or from a psychiatrist?

Yes No Are you currently under the care of a mental health professional?
If "yes": Who?_____
Where?_____
How long?_____

Yes No Have you been to the emergency room for any problem in the past year?

Past and present legal problems: _____
_____
_____

_____ _____/_____
Staff Signature Date Time

Withdrawal Risk Screening Rating

Risk Rating of "1": No symptoms or signs of current intoxications or withdrawal

Risk Rating of "2": Mild or transient signs of symptoms. No impending threat to health and no history of evidence of potential significant medical complications.

Risk Rating of "3": Moderate signs or symptoms representing a threat of health but manageable through support, observation, reassurance, daily medical monitoring and management on an ambulatory basis, and self-administration of fluids, foods, food supplements and prescribed medications.

Risk Rating of "4": Signs and symptoms representing a serious threat to health or life which can only be managed in an acute care facility, or evidence of significant medical complications requiring hospital assessment/treatment or acute inpatient management and monitoring.

Preliminary diagnosis of risk will be made by Physician and/or physicians agent and documented.

Risk Level Rating Assigned by:_____
Time: _____ AM PM Date: _____

Complete notes section and go to Decision Point #

Notes:

II. All persons entering this level of care must be diagnosed by DSM IV criteria for psychoactive substance disorders, have a Nickens Withdraw Risk Scale Rating of less than "4" as documented by telephone medical personal order of preliminary admitting patient condition. None of the designated exclusion criteria in the section above apply. Persons entering treatment at this level of care must be in a state of current intoxication or at risk of withdrawal sue to the ingestion of any of the following substances:

- Alcohol
- Amphetamines
- Cannabis
- Cocaine
- Hallucinogens
- Inhalants
- Opioids
- Phencyclidine
- Sedatives, hypnotic or anxilytics
- Other type (specified)

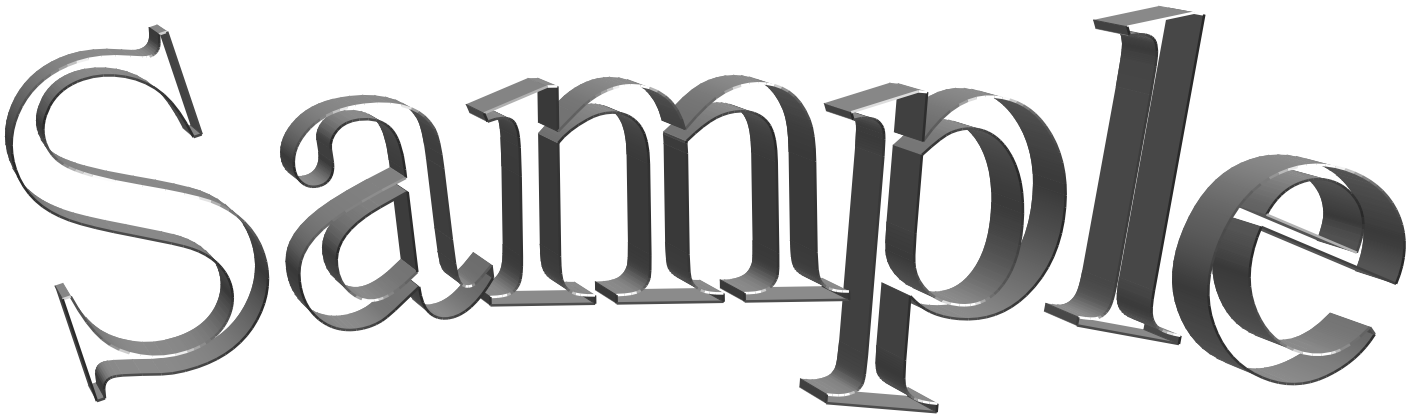
Disposition

[ ] Admit to Sobering Center for just observation
[ ] Admit to Sobering Center with recommendation for medical team assessment within 24 hours
[ ] Admit to Sobering Center with recommendation for mental health staff assessment within 24 hours
[ ] Referred for psychiatric inpatient care to: _____
[ ] Referred for inpatient detoxification to: _____
[ ] Referred to medical inpatient (non-detox) to: _____
[ ] Other referral/disposition: _____

Name of person completing this section: _____

Signature: _____

Date: _____/_____/_____
Time:_____:_____ AM PM



DEPARTMENT OF HEALTH AND HUMAN SERVICES
DIVISION OF BEHAVIORAL HEALTH SERVICES
OFFICE OF ALCOHOL AND DRUG ABUSE PREVENTION

4313 W. MARKHAM, 3RD FLOOR ADMINISTRATION
LITTLE ROCK, AR 72205
TELEPHONE 501-686-9866
FAX 501-686-9396

INCIDENT REPORT

Date Of Report:			Time of Report:
Provider:			Reported By:
1:			
Incident Date:	Time:		Location:
2:			
Subject of Report:			
Date of Birth:	Sex:	Race:	County of Residence:
Responsible Party:			Next of Kin:
3:			
Persons Involved:			
Name:	Phone Number:		Address:
a.			
b.			
c.			
d.			
e.			
4:			
Description Of The Incident:			
Comprehensive Summary of What Occurred:			

5.
Extent of Injury:
Property Loss or Damage:
6.
Outcome of the Incident:
7.
Corrective Action Taken:
8.
What Measures Could Have Prevented the Incident:
9.
Notification

Name:	Agency:	Time of Notification:
a. (OADAP Administrative Staff):	OADAP	
b.		
c.		
d.		
e.		

INCIDENT REPORT

Submit to Director of Treatment Services
Office of Alcohol and Drug Abuse Prevention
4313 W. Markham, Administration Building
Little Rock, Arkansas 72205
Telephone: 501-686-9866
Fax: 501-686-9396

Arkansas Department of Human Services
Division of Behavioral Health Services
Office of Alcohol and Drug Abuse Prevention

Licensed State Funded
Alcohol and Drug Treatment Provider Directory

Joe A. Hill, Director
Office of Alcohol and Drug Abuse Prevention
501-686-9871
E-mail: joe.hill@arkansas.gov

Garland “Sonny” Ferguson, Director
Treatment Services
501-686-9875
E-mail: garland.ferguson@arkansas.gov

Phillip D. Hall, Director
Program Compliance and Outcome Monitoring
501-686-9921
E-mail: phill.hall@arkansas.gov

http://www.arkansas.gov/dhs/dmhs/

C A	COUNTY	MAIN FACILITY	RT	OP	RADD	ATS	SWS	OTP
1 	BENTON CARROLL WASHINGTON MADISON	DECISION POINT 479 464 1060 BENTON-VILLE YOUTHBRIDGE 479 521 1532 FAYETTE-VILLE +	C C	OP OP	RADD RADD	 ATS ONLY		
2 	BAXTER BOONE MARION NEWTON SEARCY	CAROLE JONES RECOV-ERY 417-869-8911 HARRISON & MT. HOME OMART 870 435 6200 GASSVILLE +	 C	OP OP	 RADD		 SWS	
3 	CLEBURNE FULTON INDEPEND-ENCE IZARD JACKSON SHARP STONE VAN BUREN WHITE WOODRUFF	HEALTH RESOURCES OF ARK WILBUR D 501 268 7777 SEARCY+ NADC 870 793 5765 BATESVILLE +	C	OP OP	RADD		SWS	
4 	CLAY CRAIGHEAD GREENE LAWRENCE MISSISSIPPI POINSETT RANDOLPH	NORTHEAST ARK REGIONAL RECOVERY CENTER 870 932 0228 JONESBORO MIDSOUTH HEALTH SYSTEM 870 972 4032 JONESBORO +	C	OP OP	RADD			
5 	CRAWFORD FRANKLIN LOGAN POLK SCOTT SEBASTIAN	GATEWAY HOUSE 479 783 8849 FT SMITH HARBOR HOUSE 479 785 4083 FT SMITH WESTERN ARKANSAS COUN-SELING & GUIDANCE 479-478-6664 FT SMITH+	F M C	OP OP OP	RADD RADD	 ATS ONLY	SWS	

C A	COUNTY	MAIN FACILITY	RT	OP	RADD	ATS	SWS	OTP
6 	CONWAY FAULKNER JOHNSON PERRY POPE YELL	FREEDOM HOUSE 479 968 7086 RUS-SELLVILLE COUNSELING ASSC. 501 336 8300 CONWAY +	C	OP OP	RADD			
7 	CRITTENDEN CROSS LEE MONROE PHILLIPS ST FRANCIS	WILBUR D MILLS 501 268 7777 SEARCY +OP	C	OP	RADD		SWS	
8 	CLARK GARLAND HOT SPRINGS MONTGOMERY PIKE	QUAPAW HOUSE 501 767 4456 HOT SPRINGS +	C	OP	RADD	ATS	SWS	
9 	LONOKE PRAIRIE PULASKI SALINE	ARKANSAS CARES 501 661 7979 LR COUNSELING CLINIC 501 315 4224 BENTON HOOVER CENTER 501 663 4774 LR RECOVERY CENTERS OF ARK 501 372 4611 NLR + SERENITY PARK 501 663 7627 LR FAMILY SERVICE AGENCY 501 372 4242 NLR MID-ARK SUBSTANCE ABUSE SERVICES 501 686 9393 LR UAMS SUBSTANCE ABUSE TX CLINIC 501 686 9630 LR	F C M/F M CO RT	 OP OP OP OP OP	RADD		SWS	OTP

C A	COUNTY	MAIN FACILITY	RT	OP	RADD	ATS	SWS	OTP
10 	HEMPSTEAD HOWARD LAFAYETTE LITTLE RIV-ER MILLER SEVIER	RIVER RIDGE 870 774 1315 TEXARKANA + 	C	OP				
11 	CALHOUN COLUMBIA DALLAS NEVADA OUACHITA UNION	RECOVERY CENTER 870 864 2475 EL DORADO (referred)	C	OP				
12 	ARKANSAS CLEVELAND GRANT JEFFERSON LINCOLN	HDRS 870 535 3535 PINE BLUFF + SOUTHEAST ARK BEHAV-IORAL HEALTH CARE SYS-TEM 870 534 1834 PINE BLFF +	C	OP OP	RADD			
13 	ASHLEY BRADLEY CHICOT DESHA DREW	NEW BEGINNINGS CASA 870 226 9970 WARREN +	C	OP	RADD		SWS	